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ORIGINAL LECTURES.

EXSECTION OF THE HIP-JOINT.

A Clinical Lecture delivered at Bellevue Hospital Medical College.

BY LEWIS A. SAYRE, M.D.

(Specially reported for the MEDICAL NEWS by
EDWARD DEVELIN, M.D.)

GENTLEMEN: This man, M. M. D., æt. 37 years, was brought to my office a few hours ago by Dr. Barnes, of Binghamton, N. Y., who gave me the following history: Both parents and family are healthy. Patient was strong and robust until two years ago, and has been living on a farm; while ploughing, he has been in the habit of kicking the mud off the plough, and by this means the hip-joint has been injured, which has resulted in inflammation, and at the present time it has reached the stage of suppuration, with exfoliation of bone.

The patient has been wearing this long hip-splint, which is of the pattern of the first splint I devised, and which I have since condemned. Here you will observe that instead of the pelvis belt completely encircling the pelvis, it passes round but one-third of a circle, and to this is attached one perineal band, which passes under the perineum upon the side of the diseased limb; by this means the perineal band is brought more towards the diseased joint, instead of passing directly up over the pubes, as in my improved splint; by the bands passing directly up over the pubes, it lessens the liability to strangulation of the circulation, and at the same time the weight of the body passes down directly in the centre. All the instruments I have made for the past ten years are made with a complete pelvis belt, with two perineal bands. It is well for you to remember that the perineal bands pass directly up in front of the pubes, but posteriorly they are wide apart, coming across the glutei muscles; the great difficulty being that the instrument-maker will place them widely apart anteriorly, in spite of all instructions that I have given to the contrary. It is very essential that the bands be near together in front for the reason that has been already stated.

As soon as I have discovered an improvement in the construction of any of my instruments, I denounce the instrument previously made. I do not blame any gentleman living away from the cities, and who perhaps is unable to secure information upon this point as easily as those living in a large city; it is the instrument-maker who is at fault, as it his special calling to make instruments according to the most improved plan, and he should certainly know better than to offer for sale those that have been condemned.

As we continue our examination, you will observe that the right limb is two inches shorter than the left, although the limb is perfectly straight owing to Dr. Barnes' careful method of applying the extension. You will observe that there is one sinus in the groin, one below the crest of the ilium, one above the trochanter major, and another about three inches below; we have in all, four sinuses, and judging by appearances, they lead to dead bone; this you may know by their peculiar characteristic appearance, which is graphically described as representing the anus of a chicken. This dead bone is a source of irritation, and

keeps up a constant discharge from the body, emptying itself by way of these sinuses. As time goes on, granulation commences around the borders of these orifices, and becoming exuberant, is recognized as proud flesh; in this case you will observe it presents this appearance.

Whenever you find an opening of this description in such a case as is here before you, you may be certain that such an opening leads to dead bone; you may be positive upon this point. In probing these sinuses, a flexible probe should be used in order that it may follow the channel without injuring the tissues; never use any force while probing at the seat of disease. The question here is what to do in this case; nature herself is trying to exsect the hip-joint; if the patient does not succumb from the long process of suppuration, we often get remarkable results from nature's treatment; in fact, there are some gentlemen to-day who claim that this is better than surgical treatment; I must confess that I differ from that doctrine.

Here now is dead bone, and there is no hope for that man to get well until that bone is removed; now in the slow process of nature to remove that dead bone, there is a long travelling of pus through various roads which it must make for its exit; at the same time more or less of that pus will be absorbed by the system, resulting in anaemia and exhaustion. The patient informs me that while the sinuses are open and there is a free discharge of pus, he feels much better and his general health improves; this is because the poison of the broken-down tissue is not absorbed by the system, but when the openings become closed as they are apt to do for a short time, there is no escape for the pus, and hence it is returned to the system, and as a natural result constitutional disturbance ensues, followed by loss of appetite, with febrile movement, etc. This process may go on until all the diseased tissues have been thrown off, if the man can outlive the disease, but this can hardly be called the rule.

The question now arises as to the advisability of complete exsection of the bone, and the application of a drainage-tube to the wound. My own experience is that where the disease has gone on to caries of the bone, and where you have relieved the parts from reflex action, and yet the inflammation still goes on to destructive caries, that notwithstanding your extension and proper adjustment of the parts to give the patient ease, and afford him the benefit of the open air for the improvement of his general health; that notwithstanding the drains are placed in such a manner as to give free outlet to the pus; if, I say, that in spite of all these precautions the carious degeneration still goes on, then your duty is promptly to remove the diseased tissues by an operation.

If, on the other hand, the caries diminishes and the discharge from the sinuses becomes gradually less, under your precautionary measures, then you should be satisfied with your expectant treatment.

In one case of hip-joint disease Dr. Spencer removed nine inches of the femur subperiosteally, and recovery commenced from the instant, which resulted in a shortening of the bone of only three inches, with a good movable joint.

In this case by making pressure into the joint severe pain is induced, but there is a total absence of pain immediately that extension is applied.

I am very glad to find that this limb is dressed in a

proper manner, extension being made from the thigh and not from the leg alone. To illustrate this point in regard to the proper mode of extension, I can do no better than relate an incident that occurred when visiting London for the first time: A child was brought to me suffering from hip disease and in much the same condition as this man, and upon whom extension had been applied *from below the knee*; I took the child in my arms, and laying the diseased limb over one of my arms in such a position as to immediately relieve the diseased surfaces from pressure, and upon the instant the expression of the child's face turned from that of pain, to relief and contentment. When I removed the strips of adhesive plaster from the leg, one of the gentlemen present checked me, and stated that they had been following out the method of extension by making traction below the knee by the use of the adhesive plaster and roller bandage; I informed the gentlemen present that the treatment had been entirely wrong, and that instead of making traction upon the thigh, they had simply been making traction upon the ligaments of the knee-joint.

At this point Mr. Berkley Hill arose and said: "Gentlemen, I desire to explain to you why we have had such bad results from treating disease of the hip-joint according to the American plan. You must all remember the number of diseased knee-joints we have had following the treatment of the disease of the hip-joint; we have produced disease of the knee-joint by our constant traction upon the ligaments of this joint, and have thus complicated the disease already existing as just described by Dr. Sayre. I think it most remarkable that we should not have thought of it, and I thank you, Dr. Sayre, for coming here to tell us of our mistake."

A more straightforward acknowledgment of an error I have never seen. At a future time I will present this patient before you, and state the treatment required in this case.

(The patient again before the class at the following clinic.)

We now propose to dilate these various sinuses and ascertain the precise condition of the bone, as to whether we shall perform the operation of exsection. Mr. Anthony White was the first one to perform this operation, in 1821; you will find a full account of the case in Cooper's *Surgical Dictionary*. Dr. Bigelow, of Boston, performed the operation in 1852, the patient dying twelve days after. I performed the first successful operation in this country in 1854. I had been called to see the child two years before; at that time I recommended removal of the bone. I explained to the father that the hip was full of diseased bone, and that the numerous sinuses from which pus was issuing strongly indicated the necessity of an operation. He therefore consented, and I arranged for the operation to take place upon the day following. Drs. Cheeseman, Rogers, and Hoffman were the three medical gentlemen called in consultation; they condemned the operation so violently that the father came to me, and the result was the operation was postponed. I did not hear from him again until two years after, when he called upon me and said that he had been unable to find one doctor who agreed with me, but inasmuch as the child was daily becoming more exhausted, he and his wife desired the operation to take place at once, to save the child, if possible, if I could find one medical gentleman who would agree with me as to the operation. I therefore notified Drs. Parker, Hoffman, Cheeseman, and the late Jas. R. Wood, to attend and see the operation, but not one of these gentlemen would go. The operation at that time was so unknown that hardly any one would risk his reputation by even being a witness to it. Dr. Drake, a retired physician, however, said he

would like to see the operation, provided I would not hold him responsible. It proved a complete success in every way; the patient is now married and has a family; there is a little deformity with a shortening of half an inch, but there is quite considerable motion at the joint. When I reported that case and reported having motion I received a great deal of ridicule and censure. I then had the child taken down to Dr. Wood's office and there examined carefully, and proving the truth of my remarks. This, of course, stopped all further discussion upon that point.

In making your incision, it is very important to take a point midway between the anterior superior spinous process of the ilium and the trochanter major; that will bring you just over the top of the acetabulum; you then take a firm, strong knife, and plunge directly down until the knife touches the bone; then draw your knife down to the top of the trochanter major; then curve it inward, making your incision from four to eight inches, according to the extent of the bone diseased. You must be sure and make your incision *through* the periosteum. You then take a curved, probe-pointed bistoury, and make an incision through the periosteum only, at right angles to your previous incision, and at a line with the trochanter minor; then, with the periosteal elevator, peel up the periosteum from the diseased bone until you come to the digital fossa, where the rotator muscles of the thigh are inserted; here it may be necessary to use your knife, to carefully cut them off from the bone itself. After having peeled off the periosteum in this manner, the limb is to be adducted, and the diseased bone removed by a chain or small thumb-saw. If you find that you have reached healthy bone, your object is accomplished; but if, on the contrary, you find that there is yet diseased bone remaining below your section, it must be removed, perhaps necessitating a larger incision. It is, however, an absolute necessity that all dead bone be removed, to make the operation a success.

Sometimes by passing the finger into the rectum you can determine to a certain extent to what degree the caries of the acetabulum has progressed, and if the head of the bone be in its place. My assistant informs me that the internal periosteum points to great thickening of its substance. Here passing a probe into one of these sinuses, it passes in to the extent of eight inches, and I cannot say how much further it may go. Under these conditions, and discovering a large amount of pus and dead bone within the joint, exsection of the hip-joint has been determined upon.

The disease in this case being in the right thigh, it is necessary for me to stand on the left side of the patient. I shall make my incision connect these various sinuses, it being always advisable to follow this method when feasible. I therefore, as you observe, press the knife down at the point indicated, until I reach the bone, and I now make my curved incision. A broad curved spatula is now placed in either side of the wound, to hold it open; and upon further examination, we find the periosteum to be very much thickened. I now take this probe-pointed bistoury, and make my incision through the periosteum, half encircling the femur at a point below the trochanter minor, and then taking this periosteal elevator, I endeavor to peel off the periosteum; remember, it is very necessary to leave as much of the periosteum as possible; and now reaching the digital fossa, we divide the rotator muscles. Having peeled off the periosteum, I now take this small thumb-saw, and make my section below the trochanters, and with the aid of these lion-forceps withdraw the head, neck, and trochanters of the femur *en masse*. The acetabulum I find to be necrosed, and completely perforated to the internal periosteum, this, however, being intact.

Now although I have removed nearly five inches of this man's femur, I find that the bone is diseased still further down. I therefore peel off the periosteum still lower and my assistant pushing the shaft of the femur upward toward the wound, bringing the bone more fully into view and thus enabling me to remove the necrotic portion with greater facility, I find it necessary to remove another inch of the shaft in this case; this being done, I remove carefully as much as possible of the dead bone from the acetabulum and portion of the pubes which I find is also necrosed; the latter, however, is a somewhat difficult matter owing to the close proximity of the femoral artery to the diseased structures. The wound is now thoroughly washed out with a carbolized solution of a strength of one to forty.

The operation itself is very simple as you observe, but the after-treatment is extremely important, the whole secret of your success depends upon this. My assistant now carefully holds the diseased limb for fear of injuring the artery while the patient is placed in the wire cuirass, this being a wire cradle made to fit the patient with movable foot-pieces by which your extension can be maintained. I now fill the wound with Peruvian balsam, manipulating it in such a manner that it penetrates to all parts of the cavity in every possible direction. You now observe that I take this piece of oakum which is also saturated with the balsam, and carefully pack the wound in order to maintain the original shape of the periosteum, and thus as new bone is formed, it will be of serviceable thickness and strength. I now insert the drainage-tube, and put in a suture at the upper and lower portion of the wound, and endeavor to secure union of these portions of the incision by union by first intention.

You now observe that as the patient lies in the cuirass, the anus is directly over the opening posteriorly, thus allowing of free evacuations without soiling the instrument. The whole secret is to secure the sound limb as a means of counter-extension; first fastening the sound limb to the leg-piece with a roller bandage, commencing at the foot, and as you reach the knee, place a folded newspaper over it to prevent flexion; then passing your bandage around the thigh, and as you reach the perineum, bring your bandage from the perineum over the handle of the instrument at the side, by which means your counter-extension is secured.

Having now fastened the sound limb in this manner, we apply our extension straps of adhesive plaster to the diseased limb, making the extension from the thigh and never from the leg alone in these diseases of the hip-joint; these straps, you observe, are secured in the ordinary manner with the roller bandage; and the foot is now secured to the right foot-piece of the instrument, and by means of this screw at the bottom the requisite extension is made. Having effected this, we now fasten the limb to the instrument with a roller bandage, carefully padding the inequalities of the limb in order to obtain equable pressure at all points. I now moisten the wound with carbolized oil, and cover it with carbolized cotton and the usual antiseptic dressing; securing the whole with a broad roller.

This dressing can be left on for twenty-four, forty-eight, or sometimes ninety-six hours, or until such time as moisture shows itself upon the outside of it. You will also notice that I pass one or two turns of the roller over the abdomen, and thus secure perfect immobility of the parts.

The pulse and respiration of the patient are now good at the conclusion of the operation, although we have removed as large a quantity as six inches of his femur.

(Patient again before the class for the first time since the operation.)

It is now some four months since you saw this

patient's hip-joint extected, and I bring him here today to show you the result of the treatment before he leaves for his home, which he is desirous of doing tomorrow. During the intervening time since you last saw him, Dr. Keyes, in whose ward he was placed, found it necessary to make another incision, and remove further portions of necrosed bone to the extent of about another inch of the femur. At the time I performed the operation, I feared such might be the case, but as the periosteum was very thin, and firmly adherent to the shaft lower down, and the diseased portion was so extremely small in amount and in the centre of the shaft, I was in hopes Nature would have eliminated that portion without further necrosis. This fact shows how absolutely necessary it is to remove all necrosed bone when operating. There are, however, some cases in which this may, perhaps, be impossible.

We find that we now have a shortening of the limb to the extent of almost four inches. My impression is that, had the extension been properly adjusted, the shortening would not have been so great.

I now intend to apply the long hip splint, in order that the man can go out of doors and secure the benefit of the fresh air. You will notice that the sinuses are yet open, the lower ones discharging slightly, but the upper one has almost ceased, but a few drops of pus passing daily. The wound itself is entirely closed. Now having applied the long splint, I commence passive motion at the joint, in order that I may create a new joint. With the assistance of his crutches, the leg being maintained in the desired position by the proper application of the splint, he can now walk around and secure the benefit of the fresh air, in the mean time nourishing him well with a generous diet in order to build up his general constitution. The disease in time becoming entirely eradicated, the length of the right limb can be equalized by the application of the high shoe. [The man now with the aid of his crutches walked around the room, this being the first time he had been upon his feet since the operation.]

NOTE.—The patient left for his home the second day after appearing before the class at the last clinic, stating that he had no idea he could walk so well after remaining in bed for so long.

Letter from the attending physician, Dr. F. B. Brooks, received two weeks after the patient had returned home:

"CINCINNATUS, N. Y.

"DR. LEWIS A. SAYRE,

"DEAR SIR: Since coming from New York Mr. D. has been under my care, and wishes me to write you as to his present condition. The hip is doing well, drainage perfect, and everything lovely except a slight tenderness at exit of one of the drainage-tubes. Any suggestions in regard to the case will be thankfully received.

Yours truly,

"F. B. BROOKS."

Extract from letter No. 2, received thirteen days later:

"CINCINNATUS, N. Y.

"LEWIS A. SAYRE, M.D.,

"DEAR DOCTOR: I wish to address another letter to you in regard to Mr. D. The hip is doing well with the exception of a local tenderness at exit of drainage-tube, and I find this is caused by fungous granulations. I have applied the nitrate of silver, as you directed in your letter, but as it was only yesterday I cannot yet state results.

"Otherwise he is doing well, gaining flesh, pulse regular and strong, appetite excellent, and skin good color. I would be glad to hear from you soon.

"Very truly yours,

"F. B. BROOKS."

On receipt of this first letter I advised the application of nitrate of silver to the edges of the wound, as I surmised that the slight tenderness spoken of was owing to excessive granulations. The second letter proved my suspicions to be correct; since the receipt of which I have received no further details in relation to the case from Dr. Brooks.

ORIGINAL ARTICLES.

RAPID CURE OF POPLITEAL ANEURISM BY THE USE OF THE ELASTIC BANDAGE. TWO CASES, WITH REMARKS.

BY J. T. BOUTELLE, M.D.,
OF HAMPTON, VA.

ABOUT the first of February, 1883, I was consulted by a mulatto, thirty-five years of age, for a painful tumor of the knee, which proved to be a large aneurism, filling the popliteal space, bulging on both sides, and pulsating strongly. Pulsation could be felt in Hunter's canal. He was decidedly averse to any cutting operation. While I was debating in my mind what method to pursue, I happened to meet Dr. H. M. Nash, of Norfolk, Va., who mentioned in conversation that he had produced a speedy and lasting cure in a similar case by applying the Esmarch bandage from the toes to the top of the thigh, so as to empty the aneurism by pressure, then, having compressed the femoral artery above, removing the bandage, allowing one pulsation to fill the sac with blood, and immediately stopping the artery again; afterward controlling the circulation by shot-bag pressure. I decided to try this plan, and did so; though, as will be seen, my method differed considerably from his in some of the details.

On February 8th, I proceeded as follows, assisted by Dr. J. H. Peek, of Hampton. No anæsthetic was used. The Esmarch elastic bandage was applied firmly from the toes to the head of the tibia. I then continued with one of Dr. Martin's elastic bandages—No. 1 A—winding it around the knee from the head of the tibia upward, stretching the bandage to its full extent, and proceeding very slowly, waiting a little after each turn. In this way I carried the bandage to the upper third of the thigh. After the bandage was applied, the size and shape of the tumor apparently remained the same. The pressure caused very severe pain in the knee, which the patient bore with firmness. After five minutes, I compressed the femoral artery in the groin while the bandage was removed: then the pressure was removed from the artery for one or two beats of the heart, and immediately reapplied. A faint pulsation was felt in the tumor as the arterial stream was let on. Digital pressure was kept up on the femoral artery for about fifteen minutes, then gradually slackened, and as no pulsation was felt in the aneurism, I allowed the full stream to flow through the artery. This caused no pulsation, the tumor remaining hard. A shot-bag of about ten pounds weight was suspended from the ceiling and lowered upon Scarpa's triangle; this was not sufficient to stop the circulation, but lessened its force considerably. About half an hour after the

operation, severe pain came on in the ankle and shin, requiring a dose of morphine—one-half grain—for relief. The shot-bag pressure was maintained for two days, being occasionally removed for relief to the patient. Since the removal of the bandage, there has never been the slightest pulsation in the aneurism, nor any return of pain in the knee. The patient kept his bed for about ten days, and then began to walk about cautiously. In three weeks he was walking about town, and is now about to resume his occupation of cook. No edema of foot or leg followed the operation, nor was any coldness of the limb noticed at any time. In fact, with the exception of the pain in the ankle after the removal of the bandage, which was soon relieved, he has had no inconvenience other than to keep his bed.

At my request, Dr. Nash has very kindly sent me an account of his case, which I will give in his own words:

"The case of popliteal aneurism referred to in conversation with yourself as having been successfully treated with Esmarch apparatus by myself, was that of Joseph Harris, aged about fifty years at the time of the operation—Aug. 1, 1879. The aneurismal tumor was about the size of an orange, and filled the whole popliteal space.

"On the date mentioned, the patient was etherized, and assisted by my friend, Dr. Richard Bag-nall, the limb was enclosed from the toes to the middle of the thigh, and directly over the tumor, by the elastic bandage, and the tube tourniquet secured, when the rest of the bandage was removed, as is done when this apparatus is used for amputation. The tube was thus retained for nearly two hours, ether being kept up more or less all the time to cover the pain. The tube was then loosened, and the aneurismal tumor almost immediately filled with blood; and one pulsation was both seen and felt, when I at once made pressure with my thumb on the femoral above the tumor for a few minutes, after which time the tumor was, and remained, perfectly motionless, the blood which entered immediately after the removal of the tube tourniquet having coagulated. As a precaution, however, I thought it prudent to continue some pressure on the femoral for a day or two longer, which I did as well as possible under the circumstances by a bag of shot suspended from the tester of his bedstead, but which the patient's wife informed me was not kept constantly on the vessel, by reason of the pain the continuous pressure produced. Considerable edema of the leg followed the obliteration of the vessel, which was treated by rest, warmth, and finally by a Martin's elastic bandage. The recovery was complete, and the patient has done duty as a porter since that time."

I find in THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES for April, 1881, an article by Lewis A. Stimson, M.D., on the treatment of aneurism by the elastic bandage, in which he has collected sixty-two cases, the majority being popliteal. In the number for July, 1882, of the same journal is a review of a pamphlet on the subject by A. Pearce Gould, M.S., F.R.C.S., in which the number of cases is reported as seventy-two. In these cases,

although there were some differences of detail, the principle of the treatment was practically the same, viz., to maintain the sac full of blood in a stagnant condition for a considerable time until a coagulum formed. The elastic bandage was applied first to the leg below and then to the thigh above the aneurism, a tourniquet, Esmarch tubing, compressor or digital pressure being added and the apparatus kept in place for an hour or two hours completely cutting off the arterial flow. Great care was taken not to compress the aneurism. This does not appear to have been on account of possible danger from the compression, but on the theory that pressure would cause the clot to be smaller than the calibre of the sac and hence liable to be broken up when the blood stream began to flow against it. The success reported was variable, about one-half of the cases being cured. Two deaths occurred, one of which was not fairly attributable to the method pursued. In the cases of failure the patients seem to have been no worse than before the operation, and the performance of other operative measures was not precluded.

The two cases I have reported will be seen to differ radically in method and *rationale* from any of these, the chief point of difference lying in the application of the bandage to the aneurism itself. Dr. Nash completely empties the aneurism by pressure of the bandage, keeps it empty for a considerable time by the use of the Esmarch tubing, then lets on a full stream to fill the sac suddenly and arrests it, the explanation being that the blood rushing into the empty, flaccid sac, and stopping short will form a rapid and firm clot.

But my case differs essentially from his in method, and, I think, will be found to involve a quite different principle. I applied the full force of a Martin's elastic bandage over the aneurism, with the intention of squeezing out its contents, but I am confident that I did not succeed in this, for after the application of the bandage the tumor seemed scarcely at all lessened in size or altered in shape. The bandage remained in place only five minutes, no tourniquet was applied, the femoral artery was stopped by digital pressure not longer than fifteen minutes, after which time the full force of the arterial stream produced no pulsation, the tumor being hard and quiet. The shot-bag pressure was an intermittent one, and at its best only slowed the circulation slightly. I must therefore conclude that the actual pressure of the bandage upon the aneurism produced immediately a firm coagulation of its contents. If I am right in this conclusion, it is evident that the cure of popliteal aneurism by the elastic bandage becomes a much simpler matter than by the method hitherto pursued. Of course there may be danger of rupturing the aneurismal sac by too powerful pressure, but I do not think this danger will be very great if we proceed slowly with an ordinary elastic bandage, not attempting to empty the sac, but merely to compress it very firmly and evenly over its whole extent. Also by not maintaining the pressure of the bandage for a long time, and by doing away with the prolonged use of a tourniquet we greatly lessen the other dangers,

congestion of internal organs from forcing back the blood from the limb for a considerable time, and oedema, and possibly gangrene, of the limb as a result of the continued use of the apparatus. I admit the weakness of reasoning from one case, but the gratifying result of this one, and the freedom from suffering on the part of the patient, will, I hope, induce those who have the opportunity, to give this method a trial.

HYSTERO-EPILEPSY IN A BOY TEN YEARS OF AGE.

BY E. J. KEMPF, M.D.,
OF FERDINAND, INDIANA.

As hystero-epilepsy is an affection confined to adult or menstruating females, rarely occurring in females before puberty and after the menopause, and in males, it may not be without interest to report a case in a boy ten years of age, that lately came under my observation. I will endeavor to give an accurate and faithful description of the case, and venture a few remarks.

Mr. Peter G., the father of the boy, is of a strumous diathesis. Several of his brothers and sisters have died of phthisis, and he, though still free of any local manifestations of this diathesis, is weak and sickly. His wife comes from a healthy family, but is of a nervous and hysterical temperament. The patient, Frank G., is ten years old, and much too large for his age and correspondingly slim. His body was never strong, and is very much inclined to sickness—the image of his father in this respect. His mental qualities and his nervous system are like his mother's.

The boy has always been noted for his peevish and nervous disposition and his cowardice. His eyes were always restless and extremely watchful of everything. He would tell cunning lies to attain a certain end, and was noted for his hypocrisy. For these reasons he was never liked by his teachers or his comrades. At home, he was petted by both parents, as he was the first-born child and the only son. Such is the previous history.

Dr. Paul Kempf, the family physician, gives the following history:

January 2, 1883, I was called to see Frank G., ten years of age, who complained of an inability to walk, stand, or sit, and of slight pains in the limbs. Temperature and pulse are normal, bowels are constipated, no appetite, face is pale, and the body seems to be ill-nourished. Typhoid fever being prevalent at the time, I thought the symptoms to be prodromic of this disease. At my next visit, I found the patient in the same condition; no better, and no worse. Pressure along the spine, and in fact pressure anywhere, caused flinching and pain. In a few days, palpitation of the heart and noises in the ear appeared. The other symptoms remained the same, the pulse ranging from 70 to 80, and the temperature from 99° to 100° F. I gave him purgatives, and iron and quinine. But as the patient did not improve, and as I suspected some spinal trouble, I requested a consultation with Dr. W. R. McMahan. He coincided with my views, and gave it as his opinion that the case was one of commen-

ing caries of the spine in the cervico-dorsal region, the pain along the spine being sympathetic.

The treatment of iron and quinine was continued, with the addition of Horsford's Acid Phosphate. The bowels were continually constipated, and at one of my visits I removed a large quantity of hardened fecal matter from the rectum. After this, I ordered daily enemata of warm soapsuds, to prevent a re-accumulation of the feces.

About three weeks after the commencement of the sickness the patient began to constantly moan in a peculiar monotonous manner at all times except during sleep. The disease seemed to have changed its character, or was becoming more fully developed. Spasmodic contractions of the muscles of the abdomen also were noticed. A few days afterwards hallucinations and delirium set in, followed by convulsions, frothing at the mouth, peculiar cries, and tonic and clonic contractions of all the muscles. The convulsions with frothing at the mouth would first appear, to be followed by tonic contractions of the muscles of the arm, forearm, and face, and clonic contractions, in the form of opisthotonus, would close the performance. The whole attack would last twenty or thirty minutes. The patient was seemingly unconscious during the attack, but would often remark at the end: "Now I am done." From five to a dozen of these attacks would occur during the day, the patient being entirely free of them during the night. The presence of the clergyman or myself would restrain the patient from having an attack. For other and sympathizing visitors he would often, as if to accommodate them, go through with the whole performance.

By the request of Dr. Paul Kempf, I was at this time called in consultation, and I will give the further description of the case. I found the patient in bed seemingly perfectly helpless. His eyes had a peculiar glistening look, and were intensely restless. No motion, sign, or gesture of any person in the room escaped his attention. He would continually moan in a peculiar monotonous manner, stopping whenever remarks were made by some one present. If these remarks were concerning him, or if questions were put to him, he seemed for a short interval to forget to moan, but immediately noticing the omission he would recommence. The moaning seemed to be a part of the boy's make-up. On turning the patient around to try the effect of pressure along the spine, I noticed that the patient said, "it hurts," before I even touched him. On touching him either lightly or roughly over the spine or any part of the body the remark, "it hurts," was repeated. Lungs, heart, liver, spleen, stomach, and abdomen—except a slight tympanites—were normal. The body seemed tolerably well nourished, though the boy's appetite was almost nothing.

During an attack the limbs and the body become rigid, the hands and wrists twist in all shapes, and the muscles of the face are distorted. This is followed by clonic spasms, the body being opisthotonically arched, the head being thrown violently backwards and the body was violently thrown alternately on to the occiput and the heels. This stage lasted five or ten minutes. The parents and at-

tendants would try to restrain and straighten the patient during these contractions, but their efforts being futile, they at last only endeavored to prevent the patient from hurting himself by falling off the bed, by twisting his neck, etc. Weights had also been applied to both limbs to restrain the spasmodic contractions.

We agreed that the patient was suffering from hysteria, complicated with epileptiform attacks. The patient was given the following:

R.—Ammonium Bromide, 3ij.
Sodium Bromide, 3ij.
Elixir Valerianate Ammonia, . f3viii.—M.
Sig.—A tablespoonful four times a day.

The other treatment, tonics and enemata, as well as the milk diet were continued. The parents were enjoined not to sympathize in the least with the patient. All unnecessary and sympathizing visitors were to be kept out of the room. During the attacks the patient was to be severely let alone. He was to sit up in bed propped up with pillows, and gradually to be persuaded to sit up in a rocking-chair. Three days afterwards we again saw the case. He was sitting up in a rocking-chair, and for the first time for weeks was not moaning. He had only two slight attacks on the fourth day after commencing with the bromides. The treatment was continued, and instead of the enemata, the following was prescribed to regulate the bowels:

R.—Syrup Lacto-phosphate of Lime, f3ijss.
Soda Phosphate, 3j.—M.
Sig.—Two teaspoonfuls as required.

Within two weeks the patient was convalescent and able to walk about. He walks in a peculiar stoop-shouldered sneaking way, complains of occasional pains in the limbs, and often pretends pains, aches, and lameness. He therefore still needs watching and treatment. The mixture of the bromides will be given him for several months and repeated in the future whenever thought to be indicated.

The parents are instructed not to sympathize with any of the boy's suspicious complaints, and always to suspect him.

Comments.—Hystero-epilepsy is a disease affecting females of a hysterical type. It is a condition in which paroxysms occur, characterized by great intensity of the convulsive phenomena, combined with more or less marked features which recall the phenomena of epilepsy. The symptoms vary in different cases. The disease occurs generally in females during the menstruating period. Some cases were prostitutes, others had suffered extreme fright, and others had been victims of domestic tragedies. Cases are on record in which epilepsy was the first disease, hysteria being added after puberty. Other cases had hysterical aura first, soon followed by attacks of epilepsy. Although the disease is one of the menstruating female sex, cases have occurred before puberty and after the menopause. A case has been reported by M. Parisot (*Journ. de Méd. de Paris*, and THE MEDICAL NEWS, September 30, 1882) as occurring in a young man eighteen years of age.

The case herewith reported resembles what is termed hystero-epilepsy in the female. The hysterical aura preceding the epileptoid attacks for several weeks, consisted of pains in the limbs, back, neck, and other parts of the body; palpitation of the heart; the peculiar moaning; noises in the ear, hallucinations, and the contractions of the muscles of the abdomen. After three weeks followed the attacks of delirium and convulsions; of tonic contractions and distortions of the muscles of the face and limbs, accompanied by cries and frothing at the mouth, and lastly came the opisthotonic movements, or the clonic contractions. During the attacks, the patient was seemingly unconscious, though this condition may be termed "perverted or altered consciousness" (C. K. Mills, *Journal of Mental and Nervous Diseases*).

The most remarkable feature of the case is its rapid cure, the treatment being the bromides and moral force. But of course a return of the disease is probable at any time, and, knowing this, the patient will be strictly watched, and treated as soon as any symptoms of hysteria reappear.

MEDICAL PROGRESS.

THE TREATMENT OF SEVERE CATARRHAL CYSTITIS BY CYSTOTOMY.—DR. HOROVITZ, of Vienna (*Wiener med. Wochensch.*, Nos. 13 and 14), remarks on the changes that have taken place in respect to operations on the bladder. At one time lithotomy was the only operation for the removal of stone or foreign bodies from the bladder. Lithotripsy has, to a great extent, replaced it in these cases, and cystotomy is now widening the range of its applicability. He then describes cases of cystitis, which resist all treatment, whether medicinal or instrumental, and which, unless boldly taken in hand, lead on to fatal nephritis and pyelitis.

The urine in these cases varies in color, from light yellow to dark red-brown, is alkaline in reaction, with ammoniacal or fetid smell, of high specific gravity, with thick slimy deposit of mucus, pus, blood-corpuscles, epithelial cells, with crystals of triple phosphates and urate of ammonia, and large quantities of bacteria. In cases in which the kidneys are already involved, casts are to be found. The patient suffers extremely from great pain over the bladder and along the penis, from constant straining and consequent loss of sleep, and all catheterization is attended with great agony. His health is completely destroyed, by loss of sleep and appetite, by constant drain of albumen, and the accompanying febrility. The author maintains that a bladder in this condition (cystitis of the third degree, according to Dittel), resembles and must be treated like an abscess cavity, which discharges by a long and tortuous sinus, and is constantly bathed by an irritating and decomposed secretion. The urethra, even if healthy, is insufficient for the discharge of the thickened secretion, and this imperfect drainage necessarily aggravates the diseased walls of the bladder. There is also generally a loss of contractile power of the bladder, and not unfrequently a sacculated condition of that viscous, both of which also tend to retention of the secretion. In such cases, the only operation likely to be of any benefit is perineal section with free drainage.

In 1803 Bouchardat, and in 1855 Fergusson, performed cystotomy for relief of cystitis, but these cases were not published.

In 1867 Parker, of America, published an account of a case which he treated in this way in 1851.

The following is a list of all the cases published up to now:

		Cured.	Benefited.	Uncured.	Died.
Weir	collected 47 cases.	23	7	4	13
Post	published 1 "	1	..	..	..
Brass	" 1 "	..	..	..	1
Verneuil	" 2 "	1	..	..	1
Harrison	" 2 "	1	..	..	..
Thompson	" 2 "	2	..	..	..
Dittel	" 3 "	2	..	..	1
Total,	.	58	30	7	16

Thus of 58 cases, 30, or rather more than fifty per cent., were cured, while 16, or thirty per cent., died; of these, however, 15 suffered from deep-seated kidney mischief, which in all probability existed before the operation—that is to say, the operation was performed too late. The author insists on the necessity of careful examination of the kidneys by palpation, percussion, and analysis of the urine before deciding on an operation.

In 34 cases, lateral section was performed; in 5, bilateral section; in 10, median section; in 5, urethrotomy; in 2, prerectal section. Sir H. Thompson and Prof. von Dittel both consider that external urethrotomy affords quite sufficient drainage, and is less liable to secondary hemorrhage. The author considers that the condition termed by the English "irritable bladder" is not a fit case for the operation, as the symptoms depend not on an abnormal condition of the bladder, but on some disease of the kidney or urethra.

He finally describes five cases of Dittel's, of which two recovered and three died.—*London Medical Record*, June 15, 1883.

PATHOGENESIS OF, AND NERVOUS ACCIDENTS IN DIABETES.—DR. F. DREYFOUS has recently issued a pamphlet on this subject, in which, among the numerous theories, he has selected five which he places at the head of the list, and discusses in turn: 1. The gastro-intestinal theory (Bouchardat); 2, hepatic (Cl. Bernard); 3, nervous; 4, pancreatic; and 5, that theory which attributes it to nutritive trouble. This last theory has been revived by the works of Prof. Bouchard. M. Dreyfous considers diabetes as a disease acting on all the tissues. It may specially affect a particular organ, but he is averse to attributing diabetes to a lesion of a single organ; as a general disease, it must have a general cause. He therefore regards the theory of nutritive troubles, as expounded by Bouchard, as offering the best explanation of its etiology.—*Archives Gén. de Med.*, June, 1883.

PUPIL PHENOMENON IN CERTAIN PATHOLOGICAL CONDITIONS OF INFANCY.—DR. J. PARROT has noticed that, in several children affected with acute diseases of the brain or its membranes, while they were in a comatose condition, if he pinched the skin of the epigastrium sharply, the pupil suddenly and decidedly widened, sometimes to a size thrice that of what it originally stood at, and he argues that while the general sensibility is lost, the sensibility of the skin may remain. He explains the phenomena on the supposition that it is reflex through anæmia, in consequence of the skin irritation, resembling the mydriasis resulting from a deep inspiration. The cases he relates are as follows: Six of tubercular meningitis (three with, three without, post-mortem demonstration), four of hemorrhage into the pia mater (two with post-mortem), three of hydrocephalus, and two in which no cerebral lesions were found. He relates seven cases of various diseases other than of the brain, where, during the state of insensibility preceding death, he was unable

to elicit the phenomenon. The writer gives the following conclusion: "A child, with or without convulsions, which is in a state of coma, and whose pupils do not react on sharply pinching the epigastrum, is neither affected with tubercular meningitis nor with hemorrhage into the pia mater. It is in an advanced state of asphyxia, and its death is imminent."—*Edinburgh Med. Journ.*, July, 1883.

SIMPLE MEANS OF OBTAINING LOCAL ANESTHESIA.—DR. CHEIZE reports a case in which, wishing to remove an ingrowing toe-nail, and being without a spray producer, he covered the toe with a pledget the size of a crown piece, poured ether on it, and evaporated this by means of a pair of bellows; in five minutes anaesthesia was complete and lasted while the nail was removed, and the matrix seared with the actual cautery.—*Glasgow Med. Journ.*, July, 1883.

ADDISON'S DISEASE AND THE SUPRARENAL CAPSULES.—From a study of the literature bearing upon this subject, DR. CARL BURGER arrives at the following conclusions: The suprarenal capsules are, from their structure, to be classed among the blood-vascular glands, and have no important vital function to perform. They stand in no causal relation to the bronzing of the skin. This dark coloring of the skin occurs not only in Addison's disease, but may accompany a variety of cachexiae. Disease of the suprarenal capsules is not infrequent, and often runs its course without any of the recognized symptoms of Addison's disease. The greatest variety of lesions of the capsules may be seen in different cases of Addison's disease. Addison's disease depends upon an affection of the semilunar ganglia and of the solar plexus. This affection is usually caused by some disease of the suprarenal capsules, most frequently a tuberculous inflammation. Disease of the semilunar ganglia and solar plexus may arise from lesions of other organs than the suprarenal capsules, or may even be idiopathic. The symptoms of Addison's disease may thus be present without any lesion of the suprarenal capsules.—*Practitioner*, July, 1883.

MEANS OF PROVOKING THE SECRETION OF MILK.—When the milk-secretion is slow in appearing in a lying-in woman, or when it ceases from mental or moral causes, it may be made to return by cataplasms or fomentations of castor leaves applied to the breast, or by suction of the nipple, or by means of electricity. The mammary gland is slightly compressed between two sponge electrodes, and a feeble current passed through the gland for ten or fifteen minutes. This may be done twice a day. After the first few electricizations, the breasts swell, the large veins appear on the gland and the milk secretion is set up.—*L'Union Med.*, July 5, 1883.

DIARRHEA IN INFANTS.—DR. JULES SIMON, among other forms of diarrhoea, alludes to the cerebral, and says: "Diarrhoea may assume a cerebral form, that is, it may be accompanied by certain cerebral phenomena or by eclamptic convulsions, even although the diarrhoea may be but slight. As a result of a profuse drain, a comatose condition may be developed. Again, meningeal symptoms may develop and meningitis be simulated." Many of the reported cases of meningitis with recovery are, the writer thinks, only cases with meningitic symptoms. The various forms of diarrhoea are discussed in detail. For the treatment of cholera infantum, the writer recommends (1) preventive measures to be adopted during the premonitory catarrhal stage, and (2) after the full development of the affection, alcohol internally and externally, and mustard baths.—*Edinburgh Med. Journ.*, July, 1883.

HÆMATOMA OF PANCREAS.—At the meeting of the German Medical Society in Prague, on March 9, PROF. GUSSENBAUER showed a patient in whom he had punctured a blood-tumor of the pancreas (*Wiener medico-clinische Wochenschr.*, No. 13). The man was forty years of age, and had in the previous year become the subject of an acute "gastricrismus," said to be caused by a monster meal, of which sausages, beer, and spirits formed the staple portion. Since that time he had been the victim of gastric and intestinal disorder, and his complexion had changed to a yellowish-gray tint. When first examined by Gussenbauer, a fluctuating swelling was detected between the navel and the xiphoid cartilage, apparently retro-peritoneal, and of about the size of two fists. The diagnosis rested, therefore, between soft sarcoma, abscess, and cyst, including hæmatoma. The duration of the affection (about three months) was held to be against the possibility of sarcoma. The absence of pain and the fixation of the tumor were regarded as opposed to the diagnosis of abscess. The diagnosis, therefore, lay, according to Gussenbauer, between cyst and hæmatoma either of the pancreas or suprarenals. Why the idea of hæmatoma should have suggested itself to Gussenbauer does not appear. It is curious that he should have mentioned it in arriving at a diagnosis by the process of exclusion. The probability is that his knowledge of the subsequent course of the case colored these preliminary remarks on differential diagnosis. A median incision was made through the abdominal wall directly over the tumor. The parietal lamina of the peritoneum was in process of being stitched to the anterior wall of the tumor, when an accidental puncture of the swelling permitted the escape of a dark-colored fluid. By means of a trocar, 1900 cubic centimetres of the fluid contents were drawn off. The wall of the cyst was in many places smooth; in others, especially beneath the transverse colon, rough and irregular. After the cavity of the cyst had been washed out, antiseptic dressings were applied. For the first days, a sanguinolent fluid with some black lumps escaped. The fluid discharged was proved to contain blood. No fever followed the operation. After a few days, an eczematous condition was observed about the wound, such as is met with in cases of gastric fistula. Some of the discharge was collected, and found by experiment to digest albumen (forming tyrosin and leucin), and to transform starch into sugar. Prof. Gussenbauer said that the fistula had twice spontaneously ceased to discharge, but the appearance of fever necessitated the restoration of the fistula, after which the fever subsided. Examination still revealed, at the time the patient was shown, the presence of a cavity about an inch long, and rather more than an inch wide, from which the pancreatic secretion yet flowed. The conclusion at which Gussenbauer arrived was that a cyst had formed in the pancreas as the result of obstruction in the duct. This was most probably produced by the presence of a stone, the existence of which might also explain the occurrence of hemorrhage into the cyst. No mention is made of the actual detection of a calculus. The stools were not characterized by the presence of fat, and the patient presented no signs of disease beyond what have been mentioned. Prof. Chiari, in the course of some remarks on the origin of cysts in the pancreas, mentioned a case in which, as a result of "peripancreatitis," the whole of the pancreas had necrosed, and had been passed per anum. There was no doubt about the sequestrum being pancreas. The man recovered.—*Medical Times and Gazette*, June 30, 1883.

RESECTION OF THE KNEE.—Until recently, M. OLLIER has been an earnest opponent of this operation. Lately,

however, he has completely retracted everything which he has said against it, and comes out as an earnest advocate for it. He has not altered his opinion of its value in young children. His investigations and those of Prof. Humphry show that if the whole of the lower epiphysis of the femur be removed, as is often necessary, the growth of the limb is interfered with to a disastrous extent; and if the surgeon be able to preserve a part of the epiphysis, yet the disturbance occasioned by the operation to the nutrition of the actively growing portion that is left behind is so great that even then the limb is seriously shortened. On this account M. Ollier rejects altogether the operation of excision of the knee for patients under eight years of age. He further adds, in reference to this, that these patients are excellent subjects for incisions into joints, scraping, and free drainage; and that, if these measures fail, amputation is the sole resource. In this view we believe he is in accord with British surgeons.

The change that has taken place in M. Ollier's estimate of the value of excision of the knee has resulted from the success attending in his hands the use of a strictly antiseptic plan of treatment.

The method of operating that he advocates is the subperiosteal, but he would vary its details according to whether it is performed for injury or disease. For injury he recommends a single vertical median incision over the front of the joint, extending quite into the joint above the patella, and also below where the ligamentum patellæ is to be split. He then saws through the patella vertically, but before completing the excision of the articulated surfaces through the opening thus made, he makes an incision for drainage on each side into the joint, one just in front of the biceps tendon, the other in front or behind the sartorius, and subsequently he places a drain in each of them. He then divides the crucial ligaments, bends the joint fully, protrudes the femur and peels off from it the periosteum and ligamentous and tendinous attachments, and saws off the end. He treats the tibia in the same way. The sections of the patella are then wired together, and the wound closed with a drain at its upper and lower end. When operating for disease he recommends that a freer opening be made into the joint, as more room is required for the following up of all the recesses of the synovial cavity and for the treatment of the patella itself. He therefore employs an **H** incision, making a straight cut into the joint below the patella, extending laterally not quite as far as the lateral ligament, and not being quite so long as the transverse diameter of the condyles. From each extremity of this he makes a vertical cut upwards and downwards, of a length varying with the extent of the disease and the amount of bone requiring removal. In this way two small flaps are marked out, of which the lower is always the smaller. Two incisions for drainage are made at the sides of the joint, as in the other operation, care being taken to have the inner one behind the sartorius tendon, and both of them made without injury to tendons. The upper flap is then raised, the joint well explored, and the patella, if necessary, removed by shelling it out from its anterior periosteal investment. The periosteum and ligamentous and capsulated attachments are then carefully peeled off from those parts of the femur and tibia which are to be removed, and those bones are sawn across. The synovial membrane is excised or scraped, as the case may be, and an opening for drainage made at the top of the suprapatellar pouch; then the bones are united by two wire sutures, and the cutaneous incision united, special care being taken to stitch together the cut ends of the ligamentum patellæ.

M. Ollier first points out that the aim of the surgeon is to obtain bony union after excision of the knee. To

preserve the periosteum, where possible, directly aids in the ossific union of the two bones, while to leave the lateral ligaments as well as the posterior intact, is an important aid in maintaining the bony parts in exact and firm apposition. He lays considerable stress upon the importance of suturing carefully the divided ends of the ligamentum patellæ, so as to enable the quadriceps extensor muscle to counteract the tendency of the flexors to displace the tibia backwards. In cases of compound comminuted fracture into the knee-joint, M. Ollier is in favor of excision, even where a great length of bone has to be removed, and he suggests that in such cases it would be well to remove a part of the soft tissues in front of the joint; if not, when the ends of the bones are approximated the soft parts are greatly relaxed and bulge considerably around the bone, and as the flexors shorten more quickly than the extensor muscles, there is great danger of displacement of the tibia backwards, which can be prevented by artificially shortening the extensor tendon.—*Lancet*, June 30, 1883.

INFLUENCE EXERTED BY THE TREATMENT OF ONE EAR UPON THE OTHER EAR.—EITELBERG thus formulates his conclusions upon this subject:

1. In many cases the treatment of one ear causes an improvement in the hearing power of the other ear, which has not been treated, while a diminution of the hearing power is very rarely produced.

2. The greatest difference in favor of the improvement of hearing in the ear not treated occurred in cases of one-sided acute or chronic otitis media purulenta, with defective hearing in the other side.

3. In disease of both ears, when only one ear was treated, an improvement very often appeared in the other ear, not only in respect of the hearing power, but also in respect of the existing subjective noises.

4. In many cases an improvement, and even complete restoration, of the hearing power appeared in the ear not treated, not immediately upon the treatment of the other ear, but some time after.

5. In some cases, after a certain time had elapsed, the improvement in the hearing subsided and the ear returned to its former condition.—*New York Medical Journal*, July 14, 1883.

TREATMENT OF ULCER OF THE STOMACH.—DR. F. P. ATKINSON reports a case of chronic gastric ulcer, which was quickly benefited by his treatment, though she had had no relief from any previous treatment. She had taken carbonate of iron, carbonate of soda with bismuth, prussic acid and calumba, bismuth, strychnine, and pepsin, effervescent citrate of potash with Schacht's solution of bismuth, and various sedatives, with a diet of beef-tea, mutton-broth, barley-water, milk and lime-water, but without there being any change in her general condition. The tenderness, the pain, and the vomiting continued unchanged, and when he was called in to see her she said she felt so weak that she was scarcely able to stand. She was exceedingly thin, and with the exception of a flush upon her cheeks, she had not a particle of color either in her face or lips, and her pulse was quick and thready.

Complete rest in bed was ordered. A teaspoonful of Brand's liquid essence of beef, or a teaspoonful of Valentin's meat juice in a little cold water, in small quantities every four hours; a wineglassful of milk and lime-water (mixed in equal proportions) to be taken frequently, and the body to be rubbed with olive oil morning and evening. The beef essence and milk were very gradually increased, and when the pain had almost subsided a little sponge cake, bread, barley-water, arrowroot, etc., were allowed, and at last, by very slow

degrees, ordinary food replaced the liquid diet. Stimulants of all kinds were interdicted.

The medicinal treatment consisted of: 8 grains of tartrate of iron, 15 minimis of tincture of conium, 15 minimis of tincture of calumba, 15 minimis of glycerine, in one ounce of water, three times daily.

No aperients were allowed. After a time the mixture was replaced by 15 minimis of Bravais' dialyzed iron, three times a day. Since the last attack, about a year ago, the patient has very materially gained in flesh and color, and has been able to take ordinary diet, except for two or three days, and can walk four or five miles without fatigue.

After this she had another attack of vomiting, when liquor potassae had to be given for a day or two first, and koumiss seemed to agree better than the milk and lime-water.—*Practitioner*, July, 1883.

ELONGATION OF THE EXTERNAL NASAL NERVE IN THE TREATMENT OF GLAUCOMA.—A. TROUSSEAU describes, in his inaugural thesis, a mode of treatment which seems well adapted to replace other operations for glaucoma, and which is likely to take high place in ocular surgery. This new method is due to M. Badal, of Bordeaux, who has seen its good results. Troussseau considers this new operation superior both to iridectomy and sclerotomy, and claims the following advantages for it: 1. It is a very simple operation, which can, in most cases, be substituted for iridectomy, and especially sclerotomy. 2. It succeeds in some cases in which these operations would fail. 3. It may often retard the more serious operations above mentioned, or even enucleation, and may prevent their being employed. 4. It is always more acceptable to the patients, and can always be tried without inconvenience, since in case of failure, operations on the eyeball may be resorted to. 5. It should be performed in the prodromal stages of glaucoma. 6. It promptly calms the pains of glaucoma, and often prevents a return. 7. It sometimes restores acuity of vision. 8. It abates intra-ocular tension. 9. In case of failure from elongation of the external nasal nerve, it may be well to perform a similar operation on other sensitive nerves of the orbit.—*L'Union Méd.*, June 7, 1883.

MORBID CHANGES OF THE THROAT, LARYNX, AND AIR-PASSAGES IN SOME ACUTE INFECTIOUS DISEASES.—DR. E. LÖRI, of Budapest, gives the following as some of the changes which may be observed. In measles, twelve to thirty-six hours before the appearance of the skin rash, there is a diffuse or macular hyperæmia of the mucous membrane of the throat, larynx, and air-passages, diffuse usually in the mouth, macular on the tonsils and back of the throat. Within twelve hours from the appearance of this hyperæmia there occur small papules, first on the palato-glossal folds. About the time that the skin eruption appears there is profuse catarrh of pharynx, larynx, and trachea, with rapid shedding of epithelium, and frequent formation of superficial erosions. In the trachea the swelling around these latter may give rise to stenosis. According to the writer, the appearance of such ulcers in the larynx augurs the occurrence of tuberculosis. In scarlatina, the throat is affected twelve to thirty-six hours before the outbreak of the eruption. The writer states that there is often a sudden disappearance of the affection of the mouth and pharynx coincident with the eruption on the skin coming out. Frequently the eruption in the mouth closely resembles that found with measles. In rubeola there is also hyperæmia, diffuse or spotted, of the larynx and trachea. In smallpox the mouth is affected at the same time as the skin. The pustules are small and

imperfectly filled, dry up in two or three days, and in six days are only represented by red spots. Bleeding from them is very common. The writer recommends the use of ice poultices round the neck, ice internally, and such astringents as tannin applied after puncture of the pustules. In chickenpox there occurs either diffuse hyperæmia of the mucous membrane, or a few scattered pustules. In typhus and typhoid, acute catarrh of the pharynx, larynx, and trachea is of frequent occurrence, and often proceeds in the larynx to the formation of ulcers, which have little tendency to heal, and occasionally, about the sixth or eighth week of the disease, cause perichondritis. For this latter condition, "when diagnosed with certainty," the writer recommends tracheotomy as early as possible. In whooping-cough there is usually some catarrh of larynx and trachea, and bleeding from the mucous membrane is frequent. The appearance, during the course of whooping-cough, of ulcers in the larynx, the writer regards as very suspicious of the onset of phthisis.—*Edinburgh Med. Journ.*, July, 1883.

TREATMENT OF TINEA CAPITIS.—I. The group of diseases (*Herpes tonsurans*, *Porrigo favosa*, and *Porrigo decalvans*) comprehended under this title, being recognized as parasitical dermatoses, their rational treatment must, of course, be directed against the parasites. Two modes of procedure fulfilling this condition have been found preferable:

a. Epilation, which exterminates the parasites by destroying the organic structure in which they make their habitation.

b. The local application of croton tiglum, which accomplishes the same object by inflaming, without destroying, the derma and hair follicles, and thus removing the infested hairs.

2. In cases not too inveterate, a cure or decided amelioration is usually obtained within a period varying from three to eight months, and after from three to five applications of the remedy.

3. Clinical experience has shown that this treatment is not followed by any special tendency to relapse.

4. As to the other unfavorable results which have been charged to the employment of this remedy, viz., intense folliculitis, inflammation of the scalp and even the occipito-frontal aponeurosis, and erysipelas, it is precisely these evils which the croton-oil dressing, in the form recommended, is intended to avert. Neither the above symptoms, nor the alopecia which has been said to follow them, have been produced in any of our cases.

5. The only unpleasant consequences we have ever witnessed have occurred from the accidental transfer of the ointment to other surfaces, such as the conjunctiva, in which latter case a conjunctivitis might possibly arise; but this danger is easily obviated by protecting the scalp with a properly adjusted cap. We have never known such an accident to result in anything more serious than a slight conjunctival hyperæmia.

6. As to erysipelas, statistics show that it follows the croton treatment in an average of four cases out of a thousand, and that it has invariably been cured.

These risks are insignificant when measured against the extreme pain which epilation inflicts upon a child, and when also the insufficiency of the latter method is considered, since the hairs almost always break off under the operation.

7. To sum up our subject, the results of treatment by croton tiglum dressing may be pronounced highly satisfactory in *Herpes tonsurans*, and encouraging in *Porrigo favosa*, and in certain cases of *Porrigo decalvans*.—*Journ. of Cutan. and Vener. Diseases*, July, 1883.

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SATURDAY, JULY 28, 1883.

CHOLERA PROSPECTS.

EPIDEMIC cholera has made a long stride towards Europe and this country by establishing itself in Egypt, where it is now prevailing in a severe form.

There is no doubt of its existence in Cairo, and probably it has reached Alexandria, although no definite intelligence on this point has yet been received. There are rumors of cases in Malta and Trieste, but these are improbable.

The governments of Western Europe have become alarmed; extra quarantine precautions are insisted on; the Spanish Cortes has voted a million of pesetas to meet the cost of preventive measures, and even the Local Government Board of England has issued a memorandum of warning, directing measures of precaution against the introduction of the disease.

Cholera has also been increasing in India. During the year 1882, 2,240 deaths from cholera were reported in Calcutta, being more than in any year since 1869, and thus far the number of deaths this year from this cause has exceeded that of 1882.

It is possible that European governments, which seem fully alive to the danger, and have had timely warning, may be able to check the disease; but if we take the history of preceding epidemics as a guide for prophecy, the check will be only temporary. It will not be surprising if the disease does not appear in Europe for several months, and in the mean time gradually die out in Egypt. Should this be the course of events, the present panic and spasm of sanitary activity which it has produced will subside; commercial interests will

again come to the front; merchants and shipowners will be vociferous in their protests against the uselessness of quarantine; vigilance will relax, and the next thing will be rumors of cholera in European ports.

The danger to this country is comparatively small until the disease reaches Europe. It has usually, if not always, come to us by the lines of emigration from the north of Europe—from Hamburg and Southampton.

It is no guarantee against the presence of the cause of cholera in a ship that the disease did not prevail in the port of departure at the time of sailing, or that no cases have occurred on the vessel during the voyage, for it is sufficiently probable that the cause of the disease has been carried far into the country by the baggage of emigrants who showed no signs of the affection until this baggage was unpacked, to make it prudent to insist on thorough exposure and disinfection of all such material where there is any ground for suspicion that cholera may have existed in the vicinity from which the emigrants come.

It must be remembered also that the precautions taken at Canadian ports are nearly as important for our protection as those of our own.

But supposing the disease is introduced, say next spring—and there are at least three chances out of five that it will not reach us before that time, while it is about an even chance that we may have it within a year—are we prepared for it?

Remembering that the probabilities are that this is a question of local cleanliness and freedom from pollution of water-supply, we fear that the answer for many cities must be, Certainly not.

The cities where excreta are stored in cesspools and privy-vaults, where the sewers are badly constructed, foul, leaky, and in places little more than elongated cesspools, where the soil has become gradually saturated with organic matter, and where wells are used by the people because the water is cool and sparkling, even though a general water-supply has been introduced, and the cities whose general water-supply is taken from a stream into which, ten or twenty miles higher up, is discharged the sewage of a village or town—all these are in danger, and must do something more than scrape their streets and alleys, and scatter a little lime over the worst places, if they would have an insurance against an epidemic of cholera which is of real value.

THE SURGICAL TREATMENT OF EMPYEMA.

OSLER, FENGER, and JAS. C. WILSON have each contributed to our columns, lately, extremely interesting and instructive lectures or papers on empyema and its treatment, which naturally renew our interest in

the subject. The topic is old—for pleurisies with effusion doubtless have always existed—but there are few subjects indeed as to which it does no good to review our knowledge from time to time, to seek warning from our errors, encouragement from our improvements and successes, and from both to gain incentives to closer observation, deeper research, and further triumphs.

When the aspirator was first invented many jumped at once to the conclusion that this gave us the whip-hand of all such accumulations. For absolute certainty of diagnosis the aspirator is essential. It is demonstrative. But, in passing, let us add that it is often forgotten that we have always at hand a simple, effectual, and cheap aspirator in the hypodermic syringe, which for diagnostic purposes is equally efficacious.

But, while extremely useful and often curative in children and in cases of serous or sero-fibrinous effusions, it was soon found that in adults, and especially if the fluid were purulent, repeated aspiration would not cure, but give only a temporary relief. What was wanted was not only a safe, speedy, and thorough evacuation of the pus, but its *continuously* thorough evacuation. That is to say, as in the case of any other purulent accumulation, e. g., an abscess, so in purulent accumulation in the chest the same rule holds true—free exit. Different methods of reaching this result have been advocated by various practitioners. One uses a permanent canula, another a drainage-tube, a third free incisions, a fourth even resects a rib. With each of these methods we may use or modify, or discard antiseptic precautions. With each we may use injections to wash out the cavity, or not, as is judged best. Whatever modifications of details are adopted, free escape for the pus is the cardinal point to be secured, and if we can prevent decomposition of the pus, so much the better. *Il y a fagots et fagots.* So too there is pus and pus—some sweet and healthy, and some ill-smelling and decomposing. In all the latter cases certainly, and as a rule even in those in which the pus is sweet, washing out the chest with disinfectants, permanganate of potash, iodine, corrosive sublimate, etc., is clearly indicated. Carbolic acid should not be used, for the dangers of its absorption with poisonous symptoms is an undeniable risk.

Resection of the ribs, except when so close to each other as to prevent free drainage, is not advisable. Especially is this true in the resilient chest of children. On the other hand, in old cases of empyema in which the lung is held fast by adhesions and the rigid chest-wall cannot fall in to meet it, the thoracoplasty operation of Estlander, in which several ribs are resected to allow the approximation of the two surfaces, is certainly demanded.

Paracentesis is not without its dangers. The trocar if heedlessly used may wound the lung; even the moral fear of the operation or the pain attending it has produced fatal syncope, but this is so rare a possibility as to be practically disregarded, especially as both may be modified or avoided by soothing and gentle personal control of patients, and the use of local anaesthesia; too hasty withdrawal of the fluid, especially if done with forcible and uneven suction, as by a syringe, may injure the more or less firmly fastened lung and produce hemorrhage from the ruptured adhesions, or even rupture of the lung tissue with pneumothorax. To avoid injury to the lung, as well as to remove all the pus, Parker has even proposed to allow carbolized air to enter the chest by a hypodermic needle, but injections would effect both results better and avoid the dangers of pneumothorax.

But *per contra*, it is not to be forgotten that inaction has its dangers as well as action. A Fabian policy is not always the wisest. While attempting the absorption or elimination even of a serous fluid by purely medical means, sudden death may occur from acute oedema of the well lung; by hampering the heart's action if the effusion be very large in amount; by a kink in the great vessels, especially the vena cava, if the heart be greatly displaced; or by thrombosis of the pulmonary vessels or by syncope; and if these more immediate risks are escaped the remoter ones of exhaustion, septicaemia, and tuberculosis are none the less real, because deferred.

Pus is always an enemy, and must be got rid of as speedily as other indications make it wise to do it. Homén saved half of his 52 cases treated antiseptically. Fiedler has done thoracentesis 150 times in 112 patients, saving 21 in good health, 25 died or were dying with phthisis, while 66 who also had phthisis were cured so far as any return of the effusion was concerned.

PARALDEHYDE—A NEW HYPNOTIC.

EVERY addition to our resources in the direction of safe and efficient hypnotics is especially desirable. We owe to our Italian colleagues this new contribution. It may be desirable to put before our readers some exact information regarding the physical and chemical qualities of this substance, especially as it is likely to enact so important a *role* in the therapy of the future.

Paraldehyde is a polymeric modification of aldehyde. What is aldehyde? This is, in brief, alcohol deprived of its hydrogen, and although a generic term applied to a group, in this connection means acetic aldehyde. Paraldehyde being merely the same substance in respect to its atoms, but which are arranged differently, may be suspected to have

analogous properties. Above the temperature of 51° F. it is a colorless liquid, having a peculiar odor, and a specific gravity of .998. It boils at or about 225° F., and it is soluble in 8 parts of water at 52° F. Aldehyde acted on by chlorine is converted into chloral. These chemical facts indicate the position of paraldehyde from the physiological standpoint, and probably suggested its utility as a hypnotic.

For medicinal administration, the dose ranges from 3ss to 3ijss, and it is said the best results are had from the maximum dose.

In the trials made of it, paraldehyde has proved to be an admirable hypnotic, possessing most of the qualities but none of the dangers of chloral. It acts first on the cerebral hemispheres, and causes torpor without the preliminary excitement so common in the action of the sleep-producing class. After the hemisphere, the action extends to the medulla oblongata, and then to the cord. A lethal dose suspends the functions of the medulla and the respiratory centre, and the action of the heart ceases after the respiration. In respect to the effect on the heart, paraldehyde is far safer than chloral; indeed, it appears to be free from the danger which renders the administration of chloral in large doses so doubtful an expedient. Its effect as a hypnotic is not so persistent as that of chloral, but it may be maintained by the repetition of sufficient doses. No ill-effects of any kind—no after-nausea, or depression, or headache—have been observed to follow its very free administration.

Paraldehyde may be prescribed as a hypnotic in the various conditions usually requiring such a remedy—in fevers, rheumatism, gout, prurigo, etc. (Morselli). It is, however, in mental and nervous disorders that it will probably be most used. By the Italians, Albertoni, Morselli, and others, it has been prescribed with very marked success in acute mania, in the wakefulness of dementia paralytica, in hysterical paroxysms, and in insomnia arising under ordinary conditions. They have found it especially useful in that form of wakefulness caused by the fear of inability to sleep. Surely, if these statements be confirmed, an important remedy has been discovered in paraldehyde.

THE ORGANIC BASES OF URINARY CALCULI.

EBSTEIN has recently called attention to the fact that all uric acid concretions, whether in the shape of sand, gravel, or stone, contain a framework of albuminous material which remains after the uric acid is completely dissolved out. The same is true of calculous formations of oxalates and phosphates.

We cannot determine from the brief abstract which Prof. Ebstein publishes in the *Deut. med. Wochenschr.* for May 16, whether he considers this

a new fact, but we presume he does from the fact that he considers it worth while to announce it in advance of his forthcoming work on "Calculi." Be that as it may, Dr. H. Vandyke Carter, in his little book on *The Microscopic Structure and Formation of Urinary Calculi*, published in 1873, alludes to this organic basis or framework, which he speaks of as being finely granular and fibrous, as present in calculi made up of uric acid, urates, oxalate of lime, and phosphate of lime. He speaks of it as an essential part of these submorphous structures, and as especially distinct in calculi made up of urates and of phosphate of lime. The essential nature of this organic matrix was also foreshadowed by Prof. Rainey's paper, *On the Formation of Shells*, London, 1858; and Dr. W. M. Ord's paper, *On Molecular Coalescence, and on the Influence exercised by Colloids upon the forms of Inorganic Matter*, published in the *Quar. Journ. Mic. Sci.*, 1872.

Prof. Ebstein also claims to have discovered a certain relation not heretofore appreciated between the uric acid infarcts so common in the kidneys of new-born children and the general process of calculous formation. This is also promised in the forthcoming volume referred to.

THE SALTS OF LITHIA AS SOLVENTS OF URIC ACID CALCULI.

GARROD, who introduced the salts of lithia, for the purpose of alkalinizing the blood and urine, has brought forward in his Lumleian lectures, now in course of publication, fresh evidence in support of his views. Of the alkalies now employed in medicine, lithia is the most powerful as an alkali *per se*. But Dr. Roberts, of Manchester, England, an authority in renal pathology, has called in question the solvent powers of lithia, over uric acid calculi, which Garrod had strongly affirmed. Roberts submitted experimental evidence in support of his position that the salts of potash had greater activity as solvents of uric acid concretions than lithia. Dr. Garrod has, however, in the lectures above referred to, clearly shown the fallacy in Dr. Roberts' experiments, and has demonstrated anew and conclusively his original postulate that lithia is the most powerful of the alkaline group in respect to its solvent action on uric acid. Several consequences follow this demonstration: If the problem consists in the use of an alkali to effect the solution of an uric acid calculus, say lodged in the pelvis of the kidney, the agent most certain to accomplish this, is a salt of lithia.

Again—if a remedy is required to increase the alkalinity of the blood, to effect the oxidation of uric acid, and to prevent the maladies due to an excess of this acid in the blood, lithia promises the best results. We have seen from the

use of lithia, in that morbid complexus entitled lithæmia, the most conclusive evidence of its power to effect the oxidation and excretion of the offending substance. A very elegant mode of exhibiting lithia is to give the carbonate in effervescence. A granular effervescent salt is now largely used in England. The citrate in solution in water is the usual form of the remedy now prescribed in this country.

THE first number of the Journal of the American Medical Association, issued under the date of July 14th, has just come to hand. It is a double-column quarto-page journal, and contains the minutes of the late meeting of the Association, original articles on Tonsillotomy without Hemorrhage, by W. C. Jarvis, on the Treatment of Otorrhœa with Antiseptic Powders, by H. Gradle, and on the Restoration of a Lost Cheek, by a Flap from the Shoulder, by Edmund Andrews, M.D. Then follows a department of Medical Progress, an editorial on "The Change," and finally, departments of Correspondence and News Items complete the number.

Dr. N. S. Davis, when accepting the editorship, disarmed criticism by asking the Association not to expect too much of him in the first issues. It, therefore, only remains for us to express the pleasure it affords us to welcome the new journal, and cordially to wish it the fullest measure of success.

SOCIETY PROCEEDINGS.

AMERICAN OTOLOGICAL SOCIETY.

Sixteenth Annual Meeting, held in the Catskill Mountains, July 17, 1883.

(Specially reported for THE MEDICAL NEWS.)

THE American Otological Society held its Sixteenth Annual Meeting at the Hotel Kaaterskill, Catskill Mountains, N. Y., on Tuesday, July 17th.

The Society was called to order at 10.30 A. M. by the Vice-President DR. J. S. PROUT, of Brooklyn, N. Y.

Twenty-three members were present. Four new members were elected.

After the routine business the order of the bulletin was taken up, on which the titles of thirteen communications were presented.

DR. W. W. SEELY, of Cincinnati, Ohio, reported

A CASE OF PRIMARY EPITHELIOMA OF THE AURICLE; REMOVAL OF THE ENTIRE AURICLE BY THERMOCAUTERY.

The case was that of a man, sixty years old, who had been bitten, while asleep on the right ear by a rat. The wound never healed, though treated in various ways, and presented at the time he was first seen by Dr. S., a large, sensitive, readily bleeding sore. It had developed rapidly during the last year, and bled at the slightest irritation, so that the man had an exhausted and anxious appearance. The original point of the wound was near the summit of the helix; at the time of Dr. S.'s first examination it involved a large portion of the auricle. The entire auricle, except the lobule was swollen and reddened; the skin behind the ear

for some distance was reddened, but not infiltrated, the glands not enlarged. The entire auricle was removed by thermo-cautery (Paquelin's); slight hemorrhage; three or four small arteries spurting a little, till touched; the surface entirely covered with a thick layer of boracic acid. The suppuration was but slight and the patient sent home in less than five weeks with a perfectly smooth scar. The orifice of the meatus retained its normal calibre.

The author quoted a few cases which have been reported in the literature of otology, and from the small number of these cases, comes to the conclusion that primary epithelioma of the auricle is a rare disease, notwithstanding the English translation of Politzer would make it appear to be by no means rare. The specimen was presented with the paper.

DR. J. A. ANDREWS, of Stapleton, Staten Island, presented a paper on *The Intermittent Perception of Sound, as Conveyed through the Air and the Cranial Bones, with a Brief Summary of the Results of Treatment in Chronic Aural Affections, with Impaired Hearing*, which was read by title and referred to the Committee on Publication.

DR. J. A. ANDREWS also presented a paper on

THE RECOGNITION OF BRAIN COMPLICATIONS IN AURAL AFFECTIONS.

Five cases were detailed from his own experience, in which death occurred secondary to an aural affection. He called special attention to the importance of examining the eye in aural affections in which other symptoms, although obscure, excited suspicion of an intra-cranial complication. In all of his cases an ophthalmoscopic examination revealed papillitis. He considered the condition of the disk, either papillitis or a hazy, slightly cœdematous appearance of the optic-nerve disk, a very valuable corroborative evidence of a cerebral complication, especially where the other symptoms were obscure. Dr. Andrews considered the character of the headache as an important symptom. He believed that it was more continuous, occurred less in paroxysms in abscess of the brain than the headache in brain tumor. Fever was very often absent, even in the terminal stage. From his own observations, the sight is most affected on the side of the cerebral lesion.

In connection with this subject, DR. S. SEXTON, of New York, presented a paper on *External and Internal Inflammation of the Mastoid, with Cases*, which was read by title and referred to the Publishing Committee.

DR. C. H. BURNETT, of Philadelphia, reported

A CASE OF MASTOID DISEASE; ARTIFICIAL PERFORATION OF THE BONE; TEMPORARY RELIEF; DEATH FROM PYÆMIA;

and DR. READ J. MCKAY, of Wilmington, Del., a case of

ACUTE DESQUAMATIVE INFLAMMATION OF THE EXTERNAL AUDITORY CANAL; ACUTE OTITIS MEDIA, MASTOIDITIS, AND CHRONIC MENINGITIS; RECOVERY.

Dr. Burnett in his paper showed that the purulent disease may not necessarily affect the brain in cases of mastoid disease, but may produce death by pyæmia of a chronic nature, affecting organs remote from the ear, as the lungs or the liver. Also, that the operation of trephining the bone is comparatively unattended with danger, and affords the one slim chance of death in cases of true intra-mastoid disease, which must necessarily furnish an embolic source, if the products of inflammation, e. g., purulent and cheesy débris, are pent up in the mastoid cavity. For in such cases there are the chances of death from embolism, while none arise from the operation. In the case reported by Dr.

Burnett, the patient survived the mastoid operation two weeks; the wound nearly healed, when the man was seized with a chill, and rapidly sank from embolic hepatitis.

Dr. McKay's case occurred in a woman, 77 years old. She was delirious and extremely ill for months. She recovered under hypodermic injections of morphine and minute doses of calomel, with liberal use of stimulants and food.

The discussion on these different papers occupied a great part of the morning session, and was continued at the evening session.

Dr. SEXTON exhibited a former patient, now a waiter at the hotel, who had been suffering from mastoid disease, in consequence of chronic suppurative otitis media complicated with *ozena*. In this case a natural opening formed, the remnant of which still showed in a dent in the bone, and he had kept this open until the discharge ceased. For treatment he had only given calcium sulphide.

In a very large number of cases of aural diseases in general, and of the mastoid in particular, he found no occasion for trephining the mastoid. He relied especially upon the calcium sulphide. If this remedy has proven unsuccessful in the hands of some of the members, it was because too large doses had been given. The dose should never exceed one-tenth of a grain. Of late he does not apply leeches. He calls attention to the frequency of the pus burrowing through the posterior wall of the meatus and he tried to favor this process and removed sequestra as soon as possible. He does not consider pain so important in regard to indications for operative interference; there is other evidence needed. Moreover, the pain is not confined to the mastoid; often the side of the tympanic cavity is the seat of the pain, more than in any nerve distribution in the mastoid cells. He asked Dr. Knapp what value the ophthalmoscopic examination had in diseases of the mastoid with brain complication.

Dr. KNAPP remarked that neuro-retinitis is not a frequent, but when present a most important symptom, because it is objective, and is positive evidence that the inflammation has extended to the cranial cavity. It is not only of very great value in determining the appropriateness of opening the mastoid in many cases, but also in furnishing us a kind of barometer, whose rise and fall (that is, increase and decrease of the neuritis) will point toward aggravation or amelioration of the tympano-mastoiditis. He has found it of peculiar value at the period when the opening of the mastoid may be allowed to close, which should not be as long as the neuro-retinitis has not yet disappeared.

In cases where the indications for opening the mastoid were doubtful, he relied more than on any other symptom upon a *constant intense pain*, radiating from the ear and mastoid over the corresponding half of the head, sometimes being more pronounced at the vertex, at other times more in the forehead or the occiput.

From the drift the discussion had taken, it would almost appear as if there were no precise indications for the opening of the mastoid. He desired to state that he considers this operation as legitimate and in many cases as unambiguously indicated as any surgical operation, for instance that of glaucoma.

In *acute* otitis, he considers it indicated when the general and cerebral symptoms, in spite of rest and antiphlogosis, are constantly increasing, the pain extends over the whole half of the head, the mastoid is tender and puffy, and especially when together with the aggravation of these symptoms a stoppage or considerable diminution of the discharge points to retention of pus, the natural escape of which cannot be re-established by warm ear-baths, steaming, poulticing, etc.

In *chronic* otitis, he considers it indicated when symptoms on the external face of the mastoid, a scantiness or absence of discharge, more or less developed cerebral symptoms with periodic aggravations and the inefficiency of local non-operative treatment demonstrate that pus, cheesy material, or sequestra are retained in the mastoid cavity. If nature has made a perforation and the disease does not tend to a speedy recovery, this opening is to be regarded as insufficient, and should be enlarged with the chisel, whereupon the probe will determine the character of the contents of the mastoid cavity, and a sharp spoon, forceps, syringe, and a drainage-tube, will secure the recovery.

Dr. GRUENING remarked that in the case shown by Dr. Sexton, it was not the sulphide of calcium, but nature, to which the recovery was due, and in order to be consistent with his theory, in place of keeping the opening made by nature open until the discharge had ceased, he should have endeavored to close that opening.

Dr. HOLT had seen forty cases of mastoid disease with three deaths in two thousand cases, but had never trephined the mastoid.

Dr. BURNETT quoted statistics from Schwartz's series of operations, to again point out the comparative freedom from danger in the operation.

Dr. STRAWBRIDGE had seen five thousand cases of purulent middle-ear disease, with about seventy cases of mastoid disease. Only one death occurred, in a child, forty-eight hours after the disease set in. Although he had thoroughly prepared himself for the operation by repeated operations on cadavers, he had never had a chance to do the operation on the living body, as he generally succeeded with poulticing and good food in relieving his cases. He believed the poulticing acted as a stimulant.

Dr. BARTLETT said that in regard to the value of ophthalmoscopic examination he had often examined a case of melancholia, occurring in his own family, and found double optic neuritis very plainly marked; that as the case advanced the appearance of the optic disks returned to a nearly normal condition, when convulsions occurred and the case died. The ophthalmoscopic appearance of neuro-retinitis descendens usually indicated an acute stage of a meningitis, and as the brain disease advanced and tissue changes supervened, with degeneration, the neuro-retinitis subsided. These objective appearances assisted very much in deciding the plan of treatment to be pursued. Mastoiditis often occurred in the lake region where he resided and he had lost cases with this disease, the attack often being so sudden and severe that little could be done. The cases always had, or had previously had, an offensive otorrhœa, were having chills at very irregular intervals and as the disease advanced would have pain about the ear, general temperature increased, diarrhoea, and also perhaps a hobbling pulse and slight bronchitis. He had never trephined, but had succeeded by poulticing the mastoid night and day with flaxseed-meal poultices applied as hot and moist as the patient could bear every half hour, in relieving the pain and urgent symptoms, and causing the mastoid to suppurate enough in forty-eight hours, or so, to show where it should be opened, when a stout scalpel was sufficient to do so. He also advised large doses of quinine, stimulants, and proper food. If he should ever have a case in which the symptoms were urgent, and poultices did not cause the mastoid to suppurate, he would not hesitate to trephine. He thought the application of leeches for pain, in such cases, contra-indicated as too depressing, the patient could not afford to lose any blood—opium was much better. He thought also that sulphide of calcium was contra-indicated in such cases, because it accelerated suppuration in every part of the body where it might be going on. If pericarditis

had commenced, it increased it; if purulent foci were being deposited in the lung or liver, it increased the suppuration about them. He thought the picture presented by such a case was one of general disease like pyæmia, and the local indication was to open and remove the poison as quickly as possible from the mastoid.

DR. E. E. HOLT, of Portland, Me., reported a case of TERATOID TUMOR OF EACH LOBE; SEVENTH RECURRANCE, WITH DIAGRAMS.

The patient was a young woman, 29 years old, of light complexion, and good average health. The morbid growths were of unusual interest in several respects:

1. They followed promptly perforation of the lobe and wearing of gold earrings.
2. They have repeatedly recurred during a period extending over twenty years.
3. They have undergone remarkable change in structure.

In proof of this latter assertion, a portion was read of a letter from Dr. J. H. Ripley, of New York, who had removed the tumors several times, and who stated that they contained nothing but dense, interlacing, fibrous tissue; and an exhaustive examination by Dr. Edward Preble, of Portland, Me., who found that the said tumor contained germinal matter in abundance, with the following tissues: myomatous and adenoid tissues, giant-cells, fibro-plastic tissue, loose areolar tissue with infiltrated fat, innumerable elastic fibres, fine and coarse fibrous tissue, hyaline, reticular, and fibro-cartilage, smooth muscle, fragments of large bloodvessels, well-developed skin with corium, papillæ, rete mucosum and epidermis, hair-follicles, hair, and sebaceous glands, together with certain unclassifiable structures.

DR. E. E. HOLT also presented some

OBSERVATIONS ON THE HEARING POWER IN DIFFERENT CONDITIONS.

He gave an account of the examination of the following series of cases: Twenty-four cases of chronic non-suppurative otitis media from private practice; twenty-four machinists, twenty-four boiler-makers, and twenty-four persons with normal ears. The hearing power was tested by the voice, tick of a stop-watch, tuning-fork, and Koenig's rods, and the average age, ratio of bone to aerial conduction, and the audibility of Koenig's rods in three series of tests were compared with each other and with the normal ear. It was ascertained that the ratio between bone and aerial conduction diminishes in a corresponding degree to that of the hearing power for the voice, and that the average audibility for the upper limits of Koenig's rods was quite equal to the average normal of 40,000 v. s. as determined by Dr. Blake. Therefore the conclusion was drawn that the loss of hearing in the machinists and boiler-makers was due much more to a defect in the conducting than in the perceptive part of the organ of hearing, for the following reasons:

1. Because of past history or present condition of catarrh of the middle ear and naso-pharynx.
2. Because the tuning-fork, when placed vibrating in the centre of the teeth, was heard louder and longer in the more affected ear, and the sound of it was invariably increased by pressing on the tragus and closing the meatus.
3. From the fact that, had there been any considerable disease of the labyrinth, they would not have responded so nearly to the normal average audibility for the upper limit of Koenig's rods, since such an astute observer as Dr. Blake, who has made extensive use of them, has never had a case of labyrinthine dis-

ease without a marked loss of hearing for the Koenig's rods.

In regard to hearing in a noise, several of the three series made a voluntary statement that they could hear better in a noise. These were carefully tested in a quiet place and then in a noise, and in every instance there was no improvement of hearing in the noise; on the other hand, when the voice was used at the same tone, it was not heard quite as well in the noise as in a quiet place.

DR. CH. J. KIPP, of Newark, made some remarks

ON THE ASSOCIATION OF AURAL DISEASE WITH SIMPLE SPARKLING SYNCHISIS OF THE VITREOUS HUMOR.

He had the records of seven cases of sparkling synchisis, in six of which aural symptoms were present. In the seventh case it was not known whether ear disease was present or not. In five of the cases where the disease was in one eye, the aural affection appeared in the ear of the same side in two cases, in both ears in three cases. In four of the cases the ear trouble was probably situated in both the middle and nerve apparatus. In one case there was chronic suppurative otitis media, which had been preceded for years by impaired hearing without otorrhœa. In the sixth case there was absolute deafness of one ear since infancy. Otological literature contains no record of similar cases, and the author thinks the association of the two afflictions in his cases may have been merely accidental. He publishes his cases with a view of inducing others to examine their cases of synchisis for aural trouble and thus settle the question.

DRS. LITTLE, WEBSTER, and KNAPP stated that since Dr. Kipp at the Fifteenth Annual Meeting made an oral communication in regard to the same subject, they have taken especial pains during the past year to examine all their cases of synchisis for aural disease, but that in every case the result was negative.

DR. C. A. TODD, of St. Louis, Mo., reported a case of *Anomalous Sebaceous Gland in Immediate Proximity to the Auricle*. Dr. Todd being absent, his paper was referred to the Publishing Committee.

THE SIGNIFICANCE OF THE TRANSMISSION OF SOUND TO THE EAR THROUGH THE TISSUES IN AURAL DISEASE,

was the title of a paper by DR. S. SEXTON, of New York. The conclusions drawn by the author are summed up in this manner: 1. When the vibrating tuning-fork, placed on teeth or vertex, is better heard through the tissues on one side, it simply indicates that the better ear excludes wholly or in part such (tissue) transmission; but it does not prove that the auditory nerve in either is affected. (Of course, if the nerve of audition be gravely affected, sound will not be heard by any method of conduction.) 2. If the conductive mechanism is absent or greatly damaged in one ear, while the other remains more or less normal, aerial transmission will be found to be ineffectual in the diseased ear, while the tuning-fork, allowed to vibrate as before, will, therefore, be best heard in the diseased ear, while its vibrations will be almost entirely excluded from the healthy ear. 3. In labyrinthine disease pure and simple, the middle ear being normal, the tuning-fork would be best heard by aerial conduction, because bone conduction would be excluded. (In those extreme cases where destructive disease of the nerve has taken place, impulses of sound may be appreciated irrespective of either the transmitting or labyrinthine structures; thus the deaf-mute is conscious of the sound of thunder, artillery, drums, stamping with the foot upon the floor, and the like.) 4. If the above deductions be true, we may conclude that the tuning-fork is of but little, if any, value in the differ-

entiation of aural disease, and the same applies to Koenig's rods.

DR. BURNETT stated that he had found the tuning-fork experiment unreliable on account of inaccuracy of the patients. His experience was very similar to that of Dr. Sexton; he lost reliance in the tuning-fork because he could not rely upon the answers of the patients.

DR. HOLT could not agree with Dr. Sexton in regard to the unreliability of Koenig's rods. It can at any moment be ascertained whether the statements are false or not. If the finger is placed upon the rod and the patient states that the vibrations are still perceived, there is of course a wrong statement, and as it is easy to interrupt the vibrations at any time this becomes an excellent means of control.

DR. KIPP had in the last years lost reliance upon the tuning-fork for the same reason as had Dr. Burnett.

DR. SEXTON exhibited

PHOTOGRAPHS ILLUSTRATIVE OF AURAL DISEASE.

The photographs included perichondritis, facial paralysis from aural disease, ear closed from adhesions during granulation, tumor of the dura mater extending through the temporal bone, fatty tumor of the ear, sloughing of the auricle from the use of gold rings, fibrous tumor, mastoid inflammation with inflammation of temporal bone, osteoma, haematocele, spontaneous cure of mastoid disease.

He also exhibited two kinds of syringes for use by patients (one a soft rubber, the other a metallic one), and a curette, lightly curved and roughened on the concave surface for the removal of foreign bodies.

Some objections were made to the use of the metallic syringe by patients, the general opinion of the members being more in favor of Davidson's syringe for this purpose.

DR. H. KNAPP, of New York, reported

AN OBSTINATE CASE OF DESQUAMATIVE OTITIS MEDIA, FINALLY CURED.

The patient, when in her third year, had scarlet fever, and otorrhoea with more or less impairment of hearing. When first seen by Dr. K., in 1876, she was thirteen years old, there were large perforations in both drumheads, moderate discharge. The posterior walls of both meatus were swollen and covered with white, scaly masses, which were insufficiently removed by syringing. The treatment after syringing consisted in dropping lukewarm water in the ear three times daily, and sulpho-carbolate of zinc one per cent., in alcohol twenty per cent., and water eighty per cent. A rapid and great improvement occurred, lasting, however, only a few days. Under different kinds of treatment this condition of alternating improvement and aggravation lasted for years. The perforations of the membrana tympani varied in size, so that sometimes nothing of the membrane could be seen, while at other times it reappeared at the periphery, forming a thick ring with a sharply defined round or oval opening, which at rare and short intervals was closed altogether. Corresponding with this was almost normal hearing power or that power greatly diminished. In the winter of 1880-81 she was advised by Dr. K. to put herself under the charge of Dr. Hackley, to try whether the insertion of an artificial drum membrane by his hands might not improve the condition. And so it did at first, but afterward it became ineffective, and the condition was as bad as before, when in 1882 she returned to Dr. K.'s treatment. He then tried stimulating treatment, cotton pellets steeped in glycerine and nitrate of silver solution. This made the scales detach themselves, the discharge became more profuse and finally polypoid growths projected from the luxuriant mucous

membrane. These were removed in two sittings, and a solution of boracic acid in absolute alcohol was instilled. Gradually improvement took place, discharge became scant, and the swollen membrane assumed almost normal thickness; finally it ceased and the drumhead formed again as a delicate, pale-grayish membrane. When in July, 1883, Dr. K. saw the patient again, the membrane was entirely restored, short process, handle and cone of light could be recognized and hearing was $v. \frac{2}{3}$.

DR. K. draws from this case the conclusion that desquamative otitis media under palliative treatment may go on, temporarily improving, then becoming worse, bursting the drumhead over and over again, and that this condition will continue until the seat of the disease is laid bare, the luxuriating parts destroyed, and the tympanic cavity and meatus entirely cleaned out. When in his case the character of the disease from being torpid became acute, it could be treated successfully.

DR. THEOBALD asked if the second drumhead was not cicatricial tissue rather than restoration of the drumhead proper.

DR. SEXTON had seen a number of cases where granular tissue came through two or three perforations, and where, for that reason, the membrane could not be seen. After removal of this granular tissue, the membrane cleared up, the perforations closed by a new growth of cutaneous layer, but not of membrana tympani proper.

DR. JONES had seen three cases of entire reforming of the membrana tympani.

DR. THEOBALD thought such cases must be very closely examined. He had often seen partial restoration, and if this would come from many points it might be called a reforming of the drumhead, but not in the sense he alluded to, that is, a normal membrana tympani with all its details.

DR. MCKAY had in no case found reforming of the membrana tympani in the sense of its being a regular drumhead.

DR. MERRILL had seen one case of entire destruction of the drumhead, where in five weeks time it had entirely repaired with perfect hearing power.

The morning session lasted from 10.30 A. M. to 2 P. M.; the evening session from 7.30 to 11.30 P. M. At the close of the evening session the following were elected

OFFICERS FOR THE ENSUING YEAR:

President.—Dr. Charles H. Burnett, of Philadelphia.

Vice-President.—Dr. J. S. Prout, of Brooklyn.

Secretary and Treasurer.—Dr. J. J. B. Vermyne, of New Bedford, Mass.

Committee on Publications.—Drs. J. J. B. Vermyne,

C. J. Blake, J. O. De Green.

Committee on Membership.—Drs. John Green, H. G. Miller, A. Mathewson.

The Society voted to meet next year the day before the Annual Meeting of the Ophthalmological Society, and at the same place.

AMERICAN OPHTHALMOLOGICAL SOCIETY.

Nineteenth Annual Meeting, held at Kaaterskill, N. Y.,
July 18 and 19, 1883.

(Specially reported for THE MEDICAL NEWS.)

WEDNESDAY, JULY 18TH, FIRST DAY.

MORNING SESSION.

The Society was called to order at 10 A. M. by the President, DR. HENRY D. NOYES, of New York, who made a few congratulatory remarks, and then appointed the following committees:

Committee on Bulletin.—Drs. F. B. Loring, of Washington, and E. W. Bartlett, of Milwaukee.

Business Committee.—Drs. John Green, of St. Louis; E. Gruening, of New York; O. F. Wadsworth, of Boston; S. Theobald, of Baltimore; and E. Dyer, of Newport.

The Treasurer's report was read and referred to Dr. David Webster, of New York, who subsequently reported that all the accounts were correct. The report was adopted.

CANDIDATES FOR MEMBERSHIP.

The following were nominated: Drs. Charles S. Turnbull, of Philadelphia; Miles Standish, of Boston; J. L. Thompson, of Indianapolis; W. T. Bacon, of Hartford; Stephen D. Ritchie, of Washington; and John Van Duyn, of Syracuse.

NEW MEMBERS.

The following were elected: Drs. B. E. Fryer, U. S. A., Fort Leavenworth, Kansas; J. A. Andrews, of Clifton, Staten Island; L. Webster Fox, of Philadelphia; J. A. Lippincott, of Pittsburg; J. L. Minor, of New York; and E. E. Holt, of Portland, Me.

INVITED GUESTS.

The following were invited to attend the sessions of the Society: Drs. T. Y. Sutphen, of Newark, N. J.; R. H. Johnston, of Philadelphia; Miles Standish, of Boston; and Swann M. Burnett, of Washington.

The Secretary, Dr. R. H. Derby, of New York, read the resignation of Dr. Thomas G. Morton, of Philadelphia, which was accepted.

INFLUENCE ON REFRACTION OF FOUR YEARS OF COLLEGE LIFE; ILLUSTRATED BY STATISTICS OF THE LAST FOUR CLASSES GRADUATED FROM AMHERST COLLEGE.

A paper on the above subject, sent by Dr. HASKET DERBY, of Boston, was read by Dr. Miles Standish, of Boston.

The author had been able in 254 instances to trace the refraction through the whole term of four years. The examinations were all personally conducted with glasses, and in the majority of the cases, certainly in all doubtful ones, with the ophthalmoscope. The results given are those obtained by glasses. The use of atropine was entirely impracticable, as the students could not have been allowed even temporarily to be disabled from the active prosecution of their studies. Dr. Derby followed the example of Emmet and Loring in stating degrees of emmetropia as slight as 0.5 D., and included nothing less. The average age of those examined was, at entrance, nineteen years; at graduation, twenty-three. The number of cases was small, it is true, but it is one of the few attempts yet recorded to trace the movement of refraction among the more highly educated during this particular period of life and for a continuous term of years.

The general results were: hypermetropia at entrance 39, at graduation 47; myopia at entrance 90, at graduation 120; emmetropia at entrance 125, at graduation 87.

Analyzing the ametropia he found under the head of manifest hypermetropia, of which there were 39 cases at entrance, 1 changed to myopia, 2 diminished, 27 remained stationary, and 9 increased in amount.

Of the myopia there were 90 cases; 32 remained stationary, 58 increased in amount.

Emmetropia. The observations concerning this class possessed peculiar interest, the results somewhat militating against theories that have found general acceptance. There were at the time of entrance, 125 cases of emmetropia; of these 86 remained emmetropic, 10 developed hypermetropia, and 29 developed myopia. The average age of those thus developing

myopia was very nearly nineteen at entrance, twenty-three at graduation. The average myopia developed amounted to nearly 1 D (0.982).

So far as these figures go, they tend to show, first, a large amount of myopia even in this country among the educated classes. The author said it was difficult to compare Dr. Loring's figures with his own, because Dr. L.'s statistics were based upon observations made between the ages of six and twenty-one, and his observations were made between the ages of eighteen and twenty-three; but all researches at the latter age go to prove that at least one-half, or very nearly, of the educated community is myopic in this as well as in other countries. Moreover, contrary to the impressions so long entertained, myopia may be acquired at or near twenty years from the same causes that produce it at an earlier age, and it may continue to progress until the course of study is completed.

The paper was discussed by Drs. Webster and Mitterdorf, of New York; Dr. Gruening, of New York, who directed special attention to the use of the term dioptric, urging that some uniform mode of spelling be adopted; Drs. Carmalt, of New Haven; Little, of Philadelphia; and Hutchinson, of Utica.

SOME IMPROVEMENTS IN INSTRUMENTS AND APPLIANCES FOR CATARACT OPERATIONS.

DR. RUSSELL MURDOCH, of Baltimore, read a paper with the above title. He exhibited an ophthalmostat, or a self-holding eye-forceps, and an eye-speculum, which were modified from those exhibited to the Society in 1874. The distinguishing features of the speculum were absence of spring and set screw. The change in the ophthalmostat was so that it seized the conjunctiva in a vertical fold, and rotated the eyeball without dragging it, and the substitution of three little hooks for one pair, which secured greater steadiness.

The new instruments consisted, first, in the combination of Graefe's knife end to end with Wecker's scissors. Second, a combination of iris-forceps with the cystome and shell spoon.

The advantages claimed for these instruments were, that an assistant is dispensed with, and that seven instruments are reduced to three in performing the modified linear extraction of cataract.

Dr. Murdoch also exhibited a bandage which could be quickly made and easily applied.

DR. GRUENING, of New York, thought that outside of the limits of civilization such complicated instruments might be useful, but that within the limits they should be discarded entirely, and that a cataract operation should not be undertaken without an assistant. Concerning the bandage, he said an ordinary flannel bandage could not be replaced by anything which had yet been brought forward. No bandage can produce the pressure that can be applied by the use of the flannel roller. It is necessary to immobilize the eye, and this cannot be done by any substitute for the ordinary flannel bandage.

The PRESIDENT remarked that he had had some experience in the use of the little forceps in fixation, and had long ago discarded the instrument because it did not give so much control over the eye as one might imagine. He had reached the conclusion that the operator's hand should guide the forceps.

DR. MURDOCH said he was well aware the gentlemen in New York could obtain an assistant at any time, but he thought there were occasions outside where it was impossible to secure an assistant, and that the instrument had been devised especially to meet such emergencies.

DR. THEOBALD, of Baltimore, believed that the eye could not be immobilized by any bandage whatever which was at all permissible, and that there was a de-

cided objection to the long flannel bandage, especially during hot weather.

DR. GRUENING said he would not insist upon the flannel bandage, but that he would insist upon the long bandage, and of late he had used gauze, dipping it into water before applying it. He believed that the eye could be perfectly immobilized if the bandage were properly applied. The first thing to be done is to fill up the orbital depression, so that when the hand is placed over it the brow and the bridge of the nose are not felt, but the hand rests entirely upon the pad, and upon that pad pressure with the bandage can be made which will render the eye entirely immobile.

DR. THEOBALD thought if Dr. Gruening would apply the bandage in the manner described to his own eye, he would find that the eyeball had not been rendered immobile.

DR. HENRY S. SCHELL, of Philadelphia, reported a case of

TUBERCLE OF THE IRIS.

The patient was a boy, nine years of age, who applied for treatment at the Will's Eye Hospital, August 29, 1881. The left eye had been painful for four days, and exhibited the general signs of ordinary plastic iritis. Atropine and mercurial ointment were prescribed. On the 16th of September, no effect had been produced by the treatment. In the latter part of October, the boy came to the Children's Hospital, suffering from well-marked coxalgia in the second stage. There was a distinct history of phthisis on the mother's side. The left eye was still somewhat painful, the pupil was immobile, and there was a ring of circumscribed injection, and projecting from the nasal side of the pupillary margin was a small, yellowish-white nodule, the size of a pin's head, and tinged with pink. This nodule gradually increased in size; the hip-joint disease progressed. The eye was enucleated, and was examined by Dr. G. B. Lawrason, of New Orleans, who reported that it consisted of two or three tubercular masses embedded in inflammatory product. The tubercles seemed to have developed in the organized inflammatory product, which nearly filled the anterior and posterior chambers.

The PRESIDENT said that within the last year a case had been under observation in New York which illustrated the difficulties in diagnosis. The patient was four years of age, and the gross appearances presented by the eye were absolutely indistinguishable from a glaucomatous condition or a metastatic choroiditis. The patient continued under observation for several weeks without much progress in the disease. The eye was then enucleated, and tubercular disease was found to be the true nature of the lesion. It was felt at the time by those who examined the patient that, in some cases, the differential diagnosis between glaucoma and tubercular disease is impossible.

TUBERCULOSIS OF THE CILIARY MUSCLE AND IRIS.

DR. O. F. WADSWORTH, of Boston, reported a case of the above character, occurring in a girl three and a half years old. Dr. Hasket Derby, of Boston, saw the patient when the process had lasted two weeks, and regarded it as a case of kerato-iritis. The pupil contracted and remained so in spite of atropia. The cornea was hazy; the lids were natural. Afterwards, when Dr. Wadsworth saw the patient, the cornea was hazy, the conjunctiva was moderately congested, there was no marked ciliary congestion, there was good anterior chamber, and the pupil was of good size. The patient died about six months afterwards. The eye, after it was removed, contained a mass of about six millimetres in thickness, the vitreous was replaced by serous fluid, and there was nothing of the lens to be seen. The iris and choroid were in place, and behind

the mass. Microscopic examination, made by Dr. Ernst, of Boston, revealed that the growth was tubercular in character, and he was also able to demonstrate the presence of bacilli. There was no evidence of pulmonary disease. It was learned late in the history of the case that the father and the father's brother died of phthisis, and that other members were subject to bronchial attacks, so called.

The paper was discussed by Drs. Prout, of Brooklyn, and Webster, of New York.

DR. S. F. MCFARLAND, of Oxford, New York, read a paper on

A PERSONAL EXPERIENCE WITH PRISMATIC GLASSES.

During his boyhood he had slight divergence occurring and disappearing at times, although seldom sufficient to attract attention. Still he had the full use of his eyes, could judge of distance as well as others, and was even expert in the sports of youth requiring binocular vision. He had no inconvenience during his studies, always enjoying the greatest comfort during the most severe and protracted application. During the autumn of 1862, he contracted typho-malarial fever in the army, and after recovering from this he found that he had lost the full and comfortable use of his eyes, which continued with the usual pain and annoyance attending a futile effort to use both eyes in conjunction, and he was compelled finally to discontinue reading almost entirely until, in January, 1866, he consulted Dr. H. D. Noyes, who gave him plain prisms of seven degrees each, bases inwards, for distance, and eight degrees each with plus thirty-six spherical for reading. At that time he had been nearly three years unable to obtain binocular vision even for a moment, but at once he was able to see distinctly. He has never discontinued their use. They have been varied from time to time, but he has always adhered to the prisms. He suffers the inconvenience that he cannot maintain continued binocular vision, but can obtain and retain it long enough for an iridectomy, or the extraction of a cataract, and even during very protracted operations, although at the expense of pain and very distressing lassitude following the effort. Without the prism he could not do these things, inasmuch as slight differences in distance would not be appreciable. With bifocal sphero-prismatic glasses he is able to do all his office work without changing, and with a reasonable amount of comfort.

DR. R. J. MCKAY, of Wilmington, Del., said that a music teacher came to him in September, 1879, who while standing directly in front of his class and moving his eyes from right to left extremely without moving his body, weakened the external recti. Dr. McKay ordered prisms with the bases external, which the patient had worn ever since with comfort, for distance only.

DR. O. F. WADSWORTH, of Boston, then read a paper

ON THE APPARENT CURVATURE OF SURFACE PRODUCED BY PRISMS.

The phenomenon is very familiar that when we look through prisms with the bases inward with a plane surface, the surface appears convex, and with the bases outward, the surface appears concave. He had not met with any exception to this phenomenon, and the communication was intended to explain it, and was the theory which had been worked out by Dr. Pierce. It was illustrated with diagrams.

DR. S. W. BURNETT, of Washington, on invitation presented a specimen of

TUBERCLE OF THE CHOROID,

accompanied with the clinical history of the case, which occurred in a colored girl, fifteen years of age.

DR. J. A. SPAULDING, of Portland, Me., then read a paper in which he reported a case of

SYMPATHETIC NEURO-RETINITIS.

The author first referred to the able works of Mauthner and Kneis, whose views are so diametrically opposed, the latter believing that the so-called cases of sympathetic neuro-retinitis are open widely to criticism. It seemed desirable, therefore, to publish and thus to offer to careful criticism every case of apparent sympathetic inflammation of the retina and optic nerve (either alone or conjoined), and above all does this appear necessary when we have, as at present, to offer one in which, so far as accurate and repeated examinations have availed, the retina and optic papillæ of one eye underwent inflammation after an injury to its mate, while at no time from the beginning of the case were there ever any visible signs of inflammation of any portion of the uveal tract. The patient was a Danish woman, fifty-six years of age, and healthy in every respect. On the 6th of January, 1883, she was struck in the eye by the horn of a cow, which rendered her at once and forever totally blind in that eye. The patient saw a flash of light, and then the sight was gone. Eleven weeks after the injury to the right eye, the patient, much reduced in health on account of the pain and irritation in the right eye and its neighborhood, came to Dr. Spaulding for consultation on the 30th of March. About four weeks after first seen, the right eye was enucleated on account of the excessive pain from which the patient was suffering. The operation was followed by excessive hemorrhage, which could not be checked by pressure or hot water, and only ceased after ligation of the artery deep in the orbit, and of a second one, which appeared to spring from a band of connective tissue uniting the globe and upper eyelid. The case subsequently progressed favorably, and the patient was sent home. No medicinal treatment was adopted. The result appears to justify the opinion of the truly sympathetic nature of the neuro-retinitis in the left eye, for the sight gradually returned to the remaining eye. The pain in the head disappeared with considerable rapidity. July 14, 1883, examination with the ophthalmoscope revealed normal left eye, vision $\frac{2}{3}$. The enucleated eye was lost. The presence of this neuro-retinitis with total loss of vision in the eye five weeks after an injury to the other and without any other visible or possible cause, such as idiopathic iritis, syphilis, cerebral lesion, etc., indicates the sympathetic nature of the disease. Iritis was excluded in any form as the possible cause of the difficulty in the left eye.

DR. WEBSTER, of New York, said he had reported two cases of sympathetic neuro-retinitis in which he enucleated the eye giving rise to the trouble, and with excellent results. The neuro-retinitis subsided, and the eye recovered with much better vision than existed before the operation was performed.

DR. PROUT, of Brooklyn, said, concerning the hemorrhage in Dr. Spaulding's case, that in one instance, after resorting to various methods unsuccessfully, he arrested the hemorrhage by digital pressure with the finger in the orbit.

DR. MITTENDORF, of New York, had employed sponge pressure, that is, applying a good-sized, soft, moist sponge over the orbit, and securing it with a roller-bandage after enucleation — to be worn for twenty-four hours, then changed and worn for the next twenty-four hours; and he had never experienced any trouble from hemorrhage or from infiltration of the lids or the orbital tissues.

DR. H. W. WILLIAMS, of Boston, said he had never had any difficulty in arresting hemorrhage by means of the sponge-tent, and was unable to see how it is

possible for hemorrhage to go on if the orbit was properly plugged in that way. However, since he had adopted the circular suture of Bowman, he did not recollect having had a case where it was necessary to apply the sponge-tent.

DR. PROUT thought the removal of the tent would be exceedingly painful.

DR. WILLIAMS remarked that the patients did not like it at all, but the pain could be reduced to its minimum by removing the sponge very quickly.

DR. DYER, of Newport, while in charge of an army ward, had between 225 and 250 cases of enucleation, and in not a single one did he experience any annoyance from hemorrhage. He always used a large sponge from which ice-water was gently squeezed into the orbit, rarely for more than ten minutes, and afterwards applied a double thickness of linen, covering it with one thickness of bandage.

DR. GREEN, of St. Louis, referred to a case in which ice-water and digital pressure had been employed without success, and finally he tamponed the orbital cavity with a narrow strip of linen, and made external pressure with a bandage which controlled the hemorrhage. The tampon was allowed to remain twenty-four hours, when it was removed without difficulty by a process of unravelling, as it were. He subsequently learned that the patient had a hemorrhagic diathesis.

DR. KNAPP, of New York, referred to a procedure for avoiding hemorrhage after enucleation, and it was to keep close to the sclerotic. If this precaution is observed, there will be very little danger from hemorrhage. The most profuse hemorrhage occurs when the optic nerve is cut, because we are likely to go into the natural cavernous tissue of the organ; but the division can be made without undue loss of blood by pressing the speculum into the orbit, and allowing the eyeball to pop out, as it were, which will facilitate the division of the nerve and removal of the ball very materially.

THE PRESIDENT had never had but one case of serious hemorrhage, which required digital pressure. He had had one case of enucleation of the eyeball for a tumor in the antrum, and in which the bleeding was so profuse that it was necessary to tampon the cavity with the ordinary kite-tail tampon, made of pledges of lint. The tampon was effectual, and was readily removed.

The paper was further discussed by Drs. W. W. Seely, of Cincinnati, and F. Buller, of Montreal, Canada.

DR. DAVID WEBSTER, of New York, then reported

THIRTY-FIVE CASES OF CATARACT EXTRACTION.

They included all the cases which he had had, good and bad, from the beginning, and all the operations were performed at the Manhattan Eye and Ear Hospital. A brief clinical history of several of the most interesting cases was given. Thirty-one different patients were operated upon: males, 20; females, 11. Their ages ranged from 30 to 83 years. Under 40 years of age, there were 2; between 40 and 50, 3; between 50 and 60, 9; between 60 and 70, 9; between 70 and 80, 8; above 80, 2. Twenty-eight eyes were operated upon while the patient was under ether. Of these, 24 were successes; 2 partial successes; and 3 failures. Seven eyes were operated upon without the use of an anæsthetic; 5 of these did well, and 2 were failures. The method of operation known as "Von Graefe's modified," was used in all cases in which it was practicable; where a preliminary iridectomy was done, the incision for the extraction of the lens was made in the same position as in the other cases. Preliminary iridectomy was performed in 6 cases; 4 by himself, and 2 by another surgeon. In only one case

of the thirty-five was there loss of vitreous, and this was the only case in which the scoop was introduced into the eye for removing the lens; and in three cases there was dislocation of the lens into the anterior chamber during the preliminary iridectomy. In one case, irido-dialysis was produced during the operation; and in one case the iris fell before the knife, on account of premature escape of the aqueous, and was cut through. In all these cases in which accidents occurred during the operation, the eyes recovered with good sight. In three cases the cornea was thin and flaccid, and became wrinkled or collapsed after evacuation of the lens.

In 2 cases there was hemorrhage from the iris immediately following the iridectomy. In 4 cases a considerable quantity of soft lens matter was left in the eye. In 1 case some inflammatory reaction was noted during recovery. This eye did well. In 4 cases there was iritis. Sloughing of the cornea occurred in 1 case, panophthalmitis in 2 cases, and in 1 there was iridocyclitis with sympathetic inflammation of the fellow eye. A second iridectomy was performed in 2 cases, in both resulting in a clear pupil, but in one failing to restore sight on account of deeper disease. Keratonyxis for pupillary membranes was performed in 7 cases, and in all successfully.

The successes, taking the results of all the cases, complicated and uncomplicated, were 27; partial successes, 2; failures, 6. Dr. Webster believed, however, in justice to himself and cataract statistics, he ought to exclude the cases of extensive corneal opacity, a case of detachment of the retina, and one other case with vitreous and perhaps deeper complications. The figures would then stand, successes, 27; partial successes, 1; failures, 2. By success he meant the standard adopted by Dr. Knapp, namely, v. $\frac{2}{3}$; partial success, ability to count fingers; failures, nothing more than perception of light.

The paper was discussed by Drs. Heyl and Strawbridge, of Philadelphia; Theobald, of Baltimore; and Carmalt, of New Haven.

DR. W. W. SEELY, of Cincinnati, then read a paper entitled

NOTES ON OCULAR THERAPEUTICS.

He directed attention, first, to the use of yellow oxide of mercury in external ocular troubles. Ten grains to the ounce of the vehicle is the best for all purposes. The less bichloride the preparation contains the less pain produced by its application. A practical point with regard to the use of yellow oxide and vaseline in conjunctival affections where there is such profusion of tears as to wash the salve out, was to substitute eserine or the bichloride in solution, to contract the bloodvessels. The strength of the bichloride solution that seems to answer every purpose is one grain to sixteen ounces of water. Such a solution is entirely painless, and has often in his hands set aside an acute catarrhal conjunctivitis of a violent type, after from one to three or four thorough drenchings of the conjunctiva. In corneal affections he uses a four-grain solution of eserine once a day, and believes that it acts altogether better than more frequent applications, either of the same or of a weaker solution. This remark applies to all classes of cases.

For the reduction of intra-ocular tension, eserine has for him done away entirely with paracentesis.

Every one has met with cases of iritis in which atropia does not seem to act promptly and satisfactorily, possibly because of the extreme vascularity of the iris. In such cases, instead of making paracentesis, and extracting blood, he instils once a day a few drops of a four-grain solution of eserine. The habit of instilling eserine once a day in iritic cases has be-

come a routine practice with him, the patient at the same time using the mydriatic in the ordinary manner. In more than one case had he seen adhesions let go after the combined use of a myotic and mydriatic that had resisted the latter alone. Iritis is the only disease in which he employs a mydriatic as a fundamental remedy.

Eserine is the remedy *par excellence* in corneal affections. In cases in which mydriasis is necessary, the latter can be produced perfectly and still the satisfactory effects of the myotic be maintained. This is illustrated in suppurative inflammation after cataract operations, formerly so unsuccessfully treated by heat and atropine.

DR. MCKAY, of Wilmington, Del., had used yellow oxide of mercury, with very favorable results in conjunctival troubles.

DR. GRUENING, of New York, said the alternate use of mydriatics and myotics for breaking up adhesions was not entirely new; he had resorted to this method as long ago as 1868. He regarded the use of eserine in iritis as an extremely dangerous practice.

DR. KNAPP, of New York, thought the alternating use of eserine and atropine was advantageous in some forms of iritis, especially the serous variety. Again, where there is increase of pressure which produces intense pain, as in certain cases of glaucoma, the pain is considerably relieved by one drop of eserine. In serous iritis the pressure is sometimes intense, and he thought that eserine could be so regulated as to prevent the noxious effects of the drug.

DR. SEELEY said he did not speak of the alternate use of eserine and atropine, but wished simply to speak of the use of eserine *once a day* for the purpose of contracting the "bloodvessels," of course, maintaining mydriasis by atropine. He had never seen a case in which eserine had produced iritis.

The paper was further discussed by Dr. Kipp, of Newark, Dr. Knapp, and Dr. McKay.

The Society then adjourned, to meet at 8 P.M.

EVENING SESSION.

The Society was called to order by the President. The minutes of the morning session were read and approved.

DR. W. F. MITTENDORF, of New York, then read a paper on

THE TREATMENT OF DETACHMENT OF THE RETINA.

During the last three years, he had treated several very extensive detachments of the retina, occurring in patients that had only one useful eye, the other being entirely blind or absent. Although no new remedy or new method had been used, it was the combination of the different plans devised for the treatment of this affection, and the mode of administering the remedies that had led to the success. After briefly referring to the causes of detachment of the retina, the writer stated that the object of the treatment must be, (1) to keep the eye as free as possible from all irritating influences, which is best done by closing both eyes, or by putting the patient into a dark room; (2) to keep the eye as quiet as possible, and to avoid all accommodative efforts, and for this purpose the eye must be kept under the influence of a mydriatic; (3) to place the absorbents in the most favorable condition; this is accomplished by means of a pressure-bandage, and he had found elastic pressure, procured by means of a rubber bandage, to be of the greatest assistance; (4) to hasten the absorption of the effused fluid if this be the cause of the detachment—this can be accomplished by the use of jaborandi or pilocarpine. He had given a hypodermic injection of one-fourth to one-sixth of a grain of pilocarpine early in the morning, and then

kept up the diaphoresis by the use of an infusion of jaborandi leaves, from forty grains to one drachm to twelve ounces of water, administered in wine-glass doses during the afternoon and evening. This treatment should be kept up for three or four weeks. He had not seen a single case in which the remedy, administered in this way, had to be discontinued on account of unpleasant symptoms.

If the detachment complicates a specific choroiditis, or if it follows a serous iritis demanding specific treatment, this may be used at the same time with the other remedies mentioned. In these cases the disease yields, as a rule, sooner than in other cases, and it will not be necessary to push the pilocarpine to so great an extent.

Dr. Mittendorf then reported in detail three cases, all of which were successfully treated. They tended to show, *First*, That in marked detachment of the retina the energetic use of jaborandi and pilocarpine will do good, especially if the patient can be kept under the influence of the drug during the entire day and for a period ranging from twenty to thirty days; *Second*, That the elastic pressure-bandage must be used at the same time; *Third*, That the patients must be kept upon the back most of the time; and *Fourth*, That the use of atropia, which is employed without causing any inconvenience to the patient, should likewise not be neglected.

The paper was discussed by Drs. Gruening, of New York, Little, of Philadelphia, Andrews, of Clifton, Staten Island, Webster, of New York, Theobald, of Baltimore.

DR. SPAULDING, of Portland, Maine, spoke of the operative treatment in these cases. He referred to a suggestion made by Mooren, that an attempt be made to remove the effusion by means of the hypodermic syringe. Having a case on hand, he tried the operation. Although he succeeded in removing a considerable quantity of the subretinal effusion, there was not much improvement except temporarily. He suggested that the method might be cultivated by placing a piece of rubber tubing between the needle and the tip of the nozzle; thus making an instrument somewhat similar to that used in the treatment of soft cataract. At least, he thought that some form of aspiration might be made applicable in these cases.

DR. WILLIAM S. LITTLE, of Philadelphia, then reported two cases of

CONGENITAL ECTOPIA LENTIS: ONE SYMMETRICAL, THE OTHER NON-SYMMETRICAL.

The first case occurred in a man, twenty-three years of age. The non-symmetrical position of the lenses in this case was of interest, and the question arose as to what influence glasses which the patient had worn might have had in producing divergence in the left eye which is now going on, the right eye doing the work. The immunity for three years, and freedom from trouble, favored strongly the opinion that the glasses had not entered as a factor in the etiology of the divergence.

A sketch of a case by Dr. J. M. Taylor, which occurred in the practice of Dr. C. S. Turnbull, of Philadelphia, was also presented. The patient wore glasses with comfort for more than a year, when he was accidentally killed.

The paper was discussed by Dr. Mittendorf, of New York, who related the history of a case.

DR. GEORGE T. STEVENS, of New York, then read a paper on

THE EMPLOYMENT OF NITROUS OXIDE AS AN ANESTHETIC IN OPHTHALMIC OPERATIONS.

He had employed it in operations about the nasal

duct, iridectomy, cystotomy, and similar short operations, and believed that it possessed several advantages, such as being less dangerous, unattended with nausea and other symptoms which are incident to the use of ether, and that it demanded for its administration far less trouble than ether or chloroform. He thought it doubtful if it could be relied upon for cataract operations.

The PRESIDENT had employed it more or less during the last ten years, and stated that the nitrous oxide had the advantages claimed for it to a certain extent. He had, however, noticed two features: first, there is likely to be a good deal of rigidity on the part of the patient in some cases. Second, it is liable to be attended with a great deal of venous congestion which gives rise to considerable hemorrhage in wounds about the eye.

DR. R. H. DERBY, of New York, had employed the nitrous oxide preliminary to prolonged anesthesia with ether, and with very gratifying results.

DR. BULLER, of Montreal, said that for some time nitrous oxide was used in the hospital in London, but with unsatisfactory results. He had resorted to the primary anesthesia produced by ether with exceedingly gratifying results.

DR. ALBERT G. HEYL, of Philadelphia, then presented

A CONTRIBUTION TO THE OPERATIVE TREATMENT OF GLAUCOMA.

After giving the ordinary method of treatment employed, and detailing the history of a case which had been under his observation, and in which he had resorted to operative treatment, he recommended the following plan as a modification of that which he had employed: It was to ligate the frontal artery and then open the supra-orbital artery and allow a few ounces of blood to escape, and then close the vessel with a ligature. He discussed at considerable length the physiological basis of the operation, and said that he wished simply to place upon record a piece of clinical experience which he thought would shed some light upon the condition of acute glaucoma. The patient upon whom he operated was suffering from chronic glaucoma when he saw him, but the case had been one of acute glaucoma in its inception.

DR. WEBSTER, of New York, recalled a case in which a California surgeon advocated ligation of the carotid early for glaucoma; performed the operation once and cured his patient.

THE PRESIDENT stated that the natural history of acute glaucoma must be considered before deciding with reference to the influence produced by any modification of the circulation by operation.

DR. SEELY, of Cincinnati, said it should be borne in mind that the influence of the California operation was directly the reverse of that suggested by Dr. Heyl.

DR. GUSTAVUS HAY, of Boston, then read a communication on the *Astigmatic Pencil*, which was discussed by Dr. Knapp, of New York.

DR. CHARLES J. KIPP, of Newark, New Jersey, then reported cases of

SARCOMA OF THE CHOROID, WITH INTERESTING CLINICAL FEATURES.

Case I. was that of a woman, seventy years of age, first seen six weeks before the eye was removed. Sight had been lost only a few months. There was no pain, nor was there any sign of inflammation of the outer parts of the eye. In the outer half of the eye, behind the lens, was seen a large white mass, of rounded form, on the surface of which were numerous hemorrhages. The retina was detached in the inner half. The diagnosis of intra-ocular tumor was made, and enucleation advised. Four weeks later, symptoms of secondary

glaucoma developed, and after the patient had endured the pain for two weeks, she consented to have the eye removed. The operation was not attended by accident, and the wound healed rapidly. On examination of the eye, a large dark tumor was found which nearly filled the eye, and which had started from the outer half of the choroid; it was covered in part by the retina, and extended anteriorly to and involved the ciliary body; it consisted of spindle-shaped cells, and contained much pigment.

Case II. was that of a man, thirty-four years of age, who was first seen seventeen months before enucleation was performed. At that time, the anterior parts of the right eye were apparently quite healthy. On the nasal side of the eye, a semi-globular protuberance was seen to project nearly to the visual axis; upwards and downwards it extended apparently nearly to the vertical meridian; anteriorly, it did not reach quite to the ciliary processes. The tumor was of a greenish-red color, and was covered by transparent retina; its surface was smooth, and its vessels were distinctly visible. The retina was slightly detached at the base of the tumor, but nowhere else. The optic disk was very pale, and its margin slightly blurred. The other parts of the choroid and retina presented nothing abnormal, except an atrophic patch in the choroid below the disk. Tension was normal; visual field defective in outer half, and much contracted, upwards, downwards, and inwards. The other eye showed numerous atrophic spots in the choroid, and pigment deposits in the retina. From the patient it was learned that twenty years ago he had had a severe attack of some eye disease, which seriously impaired the left, and somewhat the right eye—the one now containing the tumor. Since then, his sight remained the same until two months ago, when he noticed that his right eye failed. The disease from which he suffered twenty years ago was doubtless a chorido-retinitis, the results of which were plainly visible in both eyes. Seventeen months later, the patient was seen again. There was now great pain, and the eye presented the usual symptoms of secondary glaucoma. The eye was enucleated, and the wound healed rapidly. On examination, the tumor was found to have started from the choroid in the region of the macula lutea. It was very large. The retina was detached completely. The microscopical examination of the tumor showed it to be a spindle-celled melano-sarcoma.

Case III. was that of a woman forty-one years of age, who was first seen fifteen months before the eye was enucleated. At the first examination nothing abnormal except a prominence and opacity of the retina at the macular region was found. The retina for a space of about two diameters of the optic disk was grayish, and the retinal veins here were dark in color. The summit of the prominence was best seen with a + 4 dioptric glass. The retina was not detached, neither over the prominence nor anywhere else. The eye was as it had been, practically blind for some months. The case was seen from time to time for two months, during which period no marked change in the eye was observed. Thirteen months later she was seen again. She had secondary glaucoma, which had come on about two weeks before. The eye was enucleated and the wound healed rapidly. On examination a large tumor of irregular form and with very broad base was found, which had originated in the region of the macula lutea, and from there spread over the optic nerve entrance.

Case IV. A woman, forty-two years old. Sarcoma of the ciliary body and iris. Secondary glaucoma was present when the patient was first seen. The tumor did not extend to the choroid, and the microscopic examination showed that it had probably originated in the connective tissue of the ciliary muscle. It

was composed of spindle cells, and contained much pigment. Five years after the operation there was no relapse.

OSSIFICATION OF THE CHOROID.

DR. KIPP also read a paper describing a case of very extensive ossification of the choroid occurring in a young man, who, when first seen ten years ago, had a chalky cataract to which the pupil was everywhere adherent. As there were at that time no symptoms of irritation of the eye, and the case was hopeless so far as sight was concerned, no treatment was advised. The boy had been born with the cataract, according to the mother's statement. Ten years afterwards the eye became painful, and presented when then seen the appearance of irido-cyclitis. The eye was removed, and, on examination, the osseous plate lined the inner side of the choroid as far as the ciliary processes.

The communication was discussed by Dr. Howe, of Buffalo, who presented a specimen; the President, and Drs. Mittendorf and Webster, of New York.

DR. S. THEOBALD, of Baltimore, then read a paper on

TRITURATION OF THE CORTEX.

He reported two cases in which this operation was practised in connection with preliminary iridectomy to hasten the development of slowly ripening cataract. The operation consists in a kneading or bruising of the anterior cortical layers of the lens by pressure on the cornea after iridectomy and while the anterior chamber is still empty, and in accordance with the suggestion put forth by Prof. Förster, of Breslau. The trituration was done with the angle of the strabismus-hook, and in the first was imperfectly performed. In the second case the operation was performed with the smooth end of the Bowman's tortoise-shell cataract-spoon, which seemed better adapted to the purpose. In the first, the operation was followed by but slight change in the condition of the lens. In the second case, however, a very rapid development of the cataract ensued. In each case there occurred a sufficient amount of iritis to cause slight but persistent adhesions between the iris and lens at the pupillary angle of the coloboma; and in the second case it was found by oblique examination, a day or two after the operation, that near the cut edges of the iris the pigment layer had been detached from the muscular coat in a manner which was quite peculiar. That the iris should be more or less bruised, as well as the lens, however carefully the trituration be performed, appears unavoidable, and the risk of exciting inflammation in this manner seems the chief objection to the procedure. It would appear, however, that Prof. Förster has not had serious trouble from this source, as he makes no special reference to it in his paper.

DR. GRUENING, of New York, had performed the operation twice during the last year. In the first he performed a large iridectomy upward, and with the angle of the strabismus-hook treated the lens in the area of the pupil only. No iritis followed, and the lens became completely opaque within one week. He extracted it three weeks later, with very good results. In the second case he performed iridectomy upward, and again treated the lens only in the area of the pupil, and in four days the lens was completely opaque. He thought there were certainly cases in which the operation was indicated, and was attended with great gain.

DR. KIPP said that he performed the operation some time ago. The lens became opaque, and four or five days afterward it cleared up again.

DR. MITTENDORF, of New York, thought the operation was indicated, especially in certain cases in which two cataracts were formed, and his experience in the operation had been equally favorable with that reported by Dr. Gruening.

DR. KNAPP, of New York, had performed the operation once, but it did not seem to hasten the ripening of the cataract.

DR. WADSWORTH, of Boston, had performed the operation once in a patient eight years ago. There seemed to be no effect at all so far as ripening of the cataract was concerned. He thought that probably in some cases maturity of the cataract might be hastened very much by the method, while in other cases probably the result would be very slight.

THE PRESIDENT had operated eight times, and in seven cases had subsequently performed extraction. In one case marked iritis developed, but did not interfere with the subsequent recovery, and extraction was entirely satisfactory. He hoped to make a communication upon the subject which would embrace the history of all his cases with remarks.

DR. GRUENING remarked that by the area of the pupil he meant the new pupil, including the coloboma.

The paper was further discussed by Drs. Webster, of New York; Fox, of Philadelphia; Dyer, of Newport; and Theobald.

THURSDAY, JULY 19TH, SECOND DAY.

The Society was called to order at 9 A.M. by the President.

THE TREASURER moved that the annual assessment be five dollars. Adopted.

VASELINE CERATE A CONVENIENT BASIS FOR OINTMENTS INTENDED FOR APPLICATIONS TO THE EYELIDS.

DR. THEOBALD, of Baltimore, read a brief paper on the above subject, in which he stated that he had been using with much satisfaction for several months, both in private and in hospital practice, as a basis for ointments intended for application to the eyelids, a cerate made of yellow wax and vaseline, which is prepared without difficulty by melting the wax and vaseline together by gentle heat, and stirring the mixture until it hardens, combining one part of yellow wax with four of vaseline, which proportion gives the ointment sufficient firmness, except, perhaps, in very hot weather, when the proportion of wax may be increased to one to three. Dr. Theobald also exhibited a specimen of ointment of the yellow oxide of mercury, containing two grains to one drachm of vaseline cerate, which, though prepared nearly four months since and kept with no special care, still retained its bright yellow color, and had undergone no appreciable change. He had been told that cerates prepared by vaseline were in use, but was not aware that attention had been called to the convenience of employing them in the manner suggested.

DR. H. KNAPP, of New York, then read a paper in which he reported a case of

BLINDNESS FROM RETINAL THROMBUS IN CONSEQUENCE OF FACIAL ERYSPIELAS.

There is on record a certain number of cases of blindness in consequence of facial erysipelas. Their symptoms vary considerably. There is lack of ophthalmoscopic examinations during the first stage of the affection. Not long ago Dr. Knapp had the rare opportunity of observing such a case almost from the beginning to the end. Mr. E. F., forty years of age, had lived in the tropics, had had syphilis with secondary and tertiary symptoms, which were aggravated, when his business called him north. On the 2d of March, 1883, while in New York, he had an attack of erysipelas, which began upon the nose, and proceeded to the pharynx, cheeks, and orbits. The patient was under the care of Drs. Gulecke and Schottke, who kindly allowed Dr. Knapp to publish the case. The erysipelas progressed, and on March 28th he was totally blind in both eyes.

Reserving a detailed discussion of this case for publication in the *Archives of Ophthalmology*, Dr. Knapp restricted himself to the following remarks:

First. The blindness was produced by compression of the central retinal arteries and subsequent thrombosis of the retinal veins, both having been directly observed with the ophthalmoscope one day after the occurrence of the rapid, almost sudden, loss of sight.

Second. The ophthalmoscopic appearances observed from beginning to end showed no neuro-retinitis, but the successive stages of a thrombosis.

Third. The degrees of the swelling of the orbital tissue, or the establishment of collateral circulation from the choroid, permitted the return of a limited flow of blood into the retinal arteries, which, however, impeded by the blocked veins, led to renewed extravasation to the thrombosis and shrinkage of the arteries, and finally to atrophy of the optic nerve.

Fourth. Perivasculitis played no, or only an unimportant, part in the pathology of this case.

Fifth. The white segments in the veins and arteries were white thrombi and hypertrophy of the walls of the bloodvessels.

Sixth. The thrombus was present in all probability also in the orbital veins, but did not, as in other cases, extend to the cerebral sinuses.

The paper was discussed by DR. KIPP, of Newark, who stated that in the cases in which he had seen the condition described by Dr. Knapp, the retina and its immediate vicinity was in a state of inflammation, or at least opaque, but not between the veins.

DR. KNAPP thought that the segments of the veins, becoming white, could be used as a diagnostic symptom of embolism.

THE PRESIDENT had seen a case in which the process was confined more particularly to the optic nerve, with swelling and neuro-retinitis, and subsequent atrophy, and nearly absolute blindness.

DR. SEELY, of Cincinnati, had seen a case in which iodoform, used as a dressing, had produced facial erysipelas in three distinct instances.

DR. KNAPP felt certain that the iodoform had no unfavorable influence whatever in his cases.

DR. W. H. CARMALT, of New Haven, Conn., read a paper on

CHANGES IN REFRACTION RESULTING FROM A BLOW.

R. A. S., twenty years of age, student in the sophomore class in Yale College, myopic since twelve years of age, consulted him on October 23, 1882, stating that, while practising in the gymnasium the day before, he had fallen violently forward, striking his right eye upon a bolt projecting from the floor. The blow was sufficiently severe to give rise to disturbance that obliged him to keep quiet for the remainder of the day and evening, neither going about nor studying; but at the time of his visit he felt quite well again, except with reference to his eye. Wearing his glasses habitually for all purposes of vision, near or far, he now felt an uncomfortable sensation in looking through his right glass, and could see much better at distance without it, better, indeed, than he remembered ever to have seen before without glasses; but, for all that, he had a very confused sensation when looking with both eyes either with or without glasses. Four months afterwards he was again consulted, when he found, on ophthalmoscopic examination, that there was no conus at the nerve, nor other evidence of retino-choroidal trouble. By oblique illumination, no opacity of the lens was detected. On the following day he saw, at Dr. Carmalt's suggestion, Dr. Loring, of New York, in consultation. To summarize the facts of this, to his knowledge, unique case, it seemed established that in a case of myopia of very considerable and nearly

equal degrees in the two eyes, one was reduced by the impact of a blow to a condition of astigmatic myopia, which resolved itself finally into a cross astigmatism without any loss of acuity of vision or range of accommodation. After endeavoring to account for the mechanism of this change, five possibilities presented themselves: *First.* A change in the shape of the cornea. *Second.* A diminution or shortening of the axis of the globe. *Third.* A displacement or dislocation of the lens backward. *Fourth.* A change in the relative position or arrangement of the lenticular fibres. *Fifth.* A preexisting spasm of accommodation, the tonicity of which had been released by the paralytic effect of the blow.

Dr. Carmalt excluded, as did also Dr. Loring, change in the length of the eyeball, also dislocation of the lens, also the previous existence of spasm of accommodation. The remaining alternative cannot be urged from any knowledge we have of such a condition having been positively determined. It is urged rather as a refuge. All the other explanations having been disproved or not being satisfactory, is it not possible that a sudden and violent impulse could have shaken and so displaced the lenticulate articulations of the lens fibres that they became fastened in a position to correspond to (or cause) the error of refraction indicated above?

The paper was discussed by Drs. Knapp, Noyes, Seely, Webster, Buller, McKay, and F. B. Loring.

DR. E. W. BARTLETT, of Milwaukee, Wis., then read a paper entitled

A FURTHER MODIFICATION IN CATARACT EXTRACTION.

The modification proposed is to make two preliminary iridectomies in certain difficult cases, one upwards and one downwards. Dr. Bartlett then reported two cases which illustrated the modification. The modification was suggested in difficult cases only; as when the eye is very prominent; when the iris does not react to atropine, or attachments have formed between the iris and capsule; when the other eye has been lost and the least amount of risk should be taken with the other eye; and when the patient is very infirm and danger from shock is very great; and when the cataract is maturing very slowly. In such cases this modification gives the patient a better chance of securing a certain amount of sight than the method of making the whole operation at one time.

DR. GRUENING, of New York, then read a paper entitled

BLEPHAROPLASTY ACCORDING TO THE ENGLISH METHOD.

A young man sustained an injury of the face by the explosion of a petroleum lamp. As a result of the mishap the integument of almost the whole forehead, the right temple, the right cheek and corresponding half of the nose was changed into dense cicatricial tissue. The upper lid was wholly everted and its free border attached to the supra-orbital margin. To correct the deformity, the lid was detached from the orbit, the neighboring tissues undermined, the deep scar excised, the free border of both lids brought in apposition, and united by free sutures. The surface of the wound measured forty millimetres in the vertical, and fifty-five millimetres in the horizontal direction. In order to cover the defect, a flap was transplanted from the inner surface of the left arm and placed upon the wound. The flap was prepared according to Wolfe's suggestion, *i. e.*, deprived of its subcutaneous cellular and adipose tissue. After careful coaptation of the flap to the edges and the surface of the wound, goldbeater's skin and a bandage were used to maintain the flap in its position. No discoloration, no displace-

ment of the flap ensued; it united firmly with the wound, and the ectropion was corrected. To-day, *i. e.*, nine months after the operation, the flap measures fifteen millimetres in the vertical, and thirty millimetres in the horizontal direction. The shrinkage took place during the first four weeks after the operation; no further shrinkage during the last eight months. The result is very satisfactory, and would not have been obtained by any other method.

The paper was discussed by Drs. Wadsworth, of Boston; Kipp, of Newark; and Andrews, of Staten Island.

DR. MCKAY, of Wilmington, then reported a case of

LOSS OF AN EYE FROM SEWER GAS AFTER EXTRACTION OF A CATARACT.

John H., a German, brewer, sixty-one years of age, was operated upon April 16, 1882, for senile cataract without an anesthetic, by Graefe's method of linear extraction. The upward operation was performed satisfactorily, and without any accident whatever. He counted fingers immediately after the operation. The eye was covered with absorbent cotton and a light flannel pressure-bandage, without the further introduction of a mydriatic. Three and a half days after the operation, the bandage became somewhat loosened; this eye was examined, and atropia was introduced. The incision was closed; the cornea was clear; the pupillary field dark; and vision, tried for a moment, was very encouraging. The patient subsequently developed symptoms of some general disease; evidence of the contamination of the atmosphere by sewer gas was detected; and finally the eye was lost, as Dr. McKay believed, in consequence of the poisoning of the general system produced by this noxious agent.

DR. MCKAY also reported a case of

SYMPATHETIC NEURO-RETINITIS OCCURRING DURING PREGNANCY.

The patient was twenty-six years of age, and had been married ten months. In infancy she had scarlet fever, since which time the right eye had been weak. Five years ago the eye was treated for a painful inflammation by an oculist in Philadelphia, but during the last two years it had not annoyed her. When Dr. McKay saw the patient the eye was in a quiescent state of chronic irido-choroiditis with partially occluded pupil and dense opacity of the vitreous. She complained of her left eye, and reported that after a week's crocheting a sudden pain was felt in it while looking at a white wall. She was debilitated by malarial and pulmonary troubles, and was three months advanced in pregnancy. Ophthalmoscopic examination revealed hypermetropia and a faint opacity of the deep portion of the vitreous, with decided congestion of the optic disk and retina, and within two weeks the appearance of sympathetic neuro-retinitis was fully manifested, and vision was reduced to counting fingers six to eight inches in a dimly lighted room. After three months' treatment in a darkened room, with a dark bandage over her eyes, and the occasional use of a solution of atropine, to prevent iritic adhesions, inunctions of mercurial ointment to the temples, several leeches to the left temple, and a general sustaining and tonic treatment, she improved in general health, and the vitreous opacity, as well as the exudation of the optic nerve and retina, disappeared, and she recovered good vision. Her pregnancy, Dr. McKay thought, greatly and favorably modified the course of the sympathetic neuritis. The ophthalmoscopic appearances of retinitis albuminurica were looked for repeatedly, but were never found, and the fact of her vision not being again impaired whilst she had general anasarca, which developed later in the progress of the case, enabled him to regard it as a case of neuro-retinitis.

DR. L. HOWE, of Buffalo, then read a brief paper and presented a specimen which illustrated

THE DIFFICULTIES IN MAKING A DIFFERENTIAL DIAGNOSIS IN GLAUCOMA.

The patient was four months old. When first seen, at two months of age, a yellowish reflex was noticed in the interior of the eye which had been previously somewhat reddened, and vision, so far as could be determined, was much impaired. Increase of tension was scarcely perceptible, but after some hesitation it was regarded as plus one. After enucleation it was found that the entire vitreous had contracted into a small cone as a result of previous inflammation, and that the apex touched the retina, and had its interior filled with a semi-purulent yellowish substance.

DR. E. E. HOLT, of Portland, Me., then read a paper entitled

COMMOTIO RETINÆ: OR SOME OF THE EFFECTS OF DIRECT AND INDIRECT BLOWS TO THE EYE.

Dr. Holt reported four cases. In two of these the patient was struck more or less directly by a stick of wood, in one by a round rod or cane, and in the other by a flat piece of coal, striking the forehead, nose, and cheek, not hitting the eye itself. In three cases recovery was uninterrupted. In one there was a relapse, vision was reduced to a perception of light for four days, after which it began to return, and in the course of two weeks became nearly normal. Relapse then occurred and vision sank, but not so low as it was after the receipt of the injury, and recovery with a perfect eye took place much more slowly than at first. Dr. Holt gave a detailed history of this case and also of one of the others.

THE PRESIDENT remarked that Dr. Holt had reported four cases manifestly dissimilar in character. From a thorough study of the affection referred to, he had become convinced that commotio retinæ is a phenomenon which had been entirely explained upon the supposition of a fissure running through the optic foramen of the orbit, and is almost entirely a mythical supposition by itself.

DR. SEELY, of Cincinnati, thought the subject could not be dismissed so summarily as Dr. Noyes had supposed. He had reported one case which could not be explained away so readily, because a single application of electricity restored a vast amount of vision, and there was no explanation of the extreme lowering of the vision from which the patient suffered.

DR. KIPP referred to a case in which there was a fracture and subsequent blindness, and suit was brought for damages. The question which arose was, whether the case was one of congenital blindness with divergence, or was it due to injury. On further examination of the patient and the surroundings, he discovered that the mother had the same condition in the corresponding eye, and taking this into consideration, he concluded that the blindness was not due to the injury.

The paper was further discussed by Dr. Gruening, Dr. Knapp, Dr. Wadsworth, and Dr. McKay.

A paper entitled, *Two Cases of Exophthalmoplegia externa, associated with Disease of the Optic Nerve from Brain Tumor, with an account of the Post-mortem Examination*, by DR. CHARLES STEADMAN BULL, of New York, was read by title, and referred to the Committee on Publication.

INJURY TO THE EYES BY HANGING.

DR. F. B. LORING, of Washington, said that since the series of experiments reported by Dr. Dyer he had seen no communications concerning the effect produced upon the eyes by hanging, except the case re-

ported by Dr. Green, of St. Louis, which was not corroborative. He had had opportunity to observe one case, which he wished to place on record. In that instance both eyes were affected, although one was not affected so markedly as the other.

DR. GREEN remarked that his case was not corroborative of Dr. Dyer's conclusions in a certain sense; but he did not consider it valuable either as corroborative or otherwise, because the time limited for examination after the execution was too short, not being more than one hour.

DR. HOWE, of Buffalo, referred to one case in which he examined the eyes thirty-five minutes after the execution, and was unable to see any change.

DR. R. H. DERBY referred to three cases, which he had already reported, in which there were marked changes in the eye produced by hanging.

COLOBOMA OF THE CHOROID.

DR. MCKAY, of Wilmington, Del., wished to place on record three cases; in one there was coloboma of the iris. Two cases occurred in children, aged respectively seven and ten months; the other occurred in a woman twenty-eight years of age. In the child seven months of age, the coloboma of the iris occurred.

EYE-BANDAGE.

DR. THEOBALD, of Baltimore, presented an additional modification of his bandage, which he regarded as a substantial improvement. It consisted in cutting the eye-piece bias, in order to prevent the tendency to wrinkling.

IMPALPABLE POWDERS.

DR. MITTENDORF called attention to a new method of applying remedies to the eye, namely, in the form of impalpable powders or triturations. He presented several specimens of remedies prepared in this way.

THE PRESIDENT remarked that he had employed homatropin prepared in this way, and had been well pleased with the preparation.

DR. JONES asked if this method was preferable to the drops prepared by Savory & Moore.

DR. WADSWORTH, of Boston, spoke of the loss of power in a solution of eserine. Recently he had found a solution which was three years old, and it still worked perfectly well.

DR. SEELY, of Cincinnati, said that for ordinary purposes he preferred an old solution of eserine to a fresh one.

The following were elected

OFFICERS FOR THE ENSUING YEAR:

President.—Dr. H. D. Noyes, of New York.

Vice-President.—Dr. William F. Norris, of Philadelphia.

Secretary and Treasurer.—Dr. R. H. Derby, of New York.

Publication Committee.—Drs. E. G. Loring and D. B. St. John Roosa, of New York.

It was determined to hold the next Annual Meeting at Kaaterskill, New York, on the third Wednesday in July.

The Society then adjourned.

CORRESPONDENCE.

A FRAUDULENT PUBLICATION.

To the Editor of THE MEDICAL NEWS.

SIR: I have recently received several letters from physicians inquiring what is my relation to a volume entitled *An Epitome of Medicine, Surgery, and Obstetrics, Including Nervous Diseases and the Diseases*

of Women and Children, by Alfred Stillé, M.D., etc., D. Hayes Agnew, M.D., etc., R. A. F. Penrose, M.D., etc. Philadelphia: Samuel M. Miller, M.D., Publisher, 1883.

Will you permit me to state that my relation to the volume is that of a professor whose legal rights have been infringed, and whose professional rights have been treated with discourtesy; that the work both misrepresents and perverts my teaching, and has been issued without my knowledge, consent, or approval, and continues to be circulated, notwithstanding my exposure of its real character before my medical class at the close of the last session. I beg to warn all medical men that the "Epitome" is not in any sense "by" me, as its title-page declares it to be, and that I denounce it as being a false and fraudulent publication.

ALFRED STILLÉ, M.D.

PHILADELPHIA, July 20, 1883.

To the Editor of THE MEDICAL NEWS.

SIR: I am receiving letters from various sections of the country, asking for information in regard to my connection with a little volume published by a Dr. Samuel Miller, and entitled *An Epitome of Medicine, Surgery, and Obstetrics*, by Drs. Stillé, Agnew, and Penrose.

I have no desire to increase my correspondence, already too onerous, and therefore deem it best to avail myself of the columns of your widely circulated journal to inform my professional brethren that I disown any relation whatever with this miserable piece of literary larceny, published entirely without my knowledge, and only remarkable for inaccuracy, stupidity, and audacity on the part of its author.

Yours, truly,

D. HAYES AGNEW, M.D.

PHILADELPHIA, July 21, 1883.

NEWS ITEMS.

BROOKLYN.

(From our Special Correspondent.)

HEALTH OF BROOKLYN.—In the first six months of the current year the total number of deaths was 6674, at a death-rate of 21.4 per 1000. Smallpox had caused 1 death out of 11 cases; measles, 30 deaths out of 1061 cases; scarlet fever, 363 deaths out of 2146 cases; diphtheria, 239 deaths out of 713 cases. Deaths by whooping-cough were 64, and by typhoid fever 32; the cases of these diseases not being fully reported, they are not quoted. The number of vaccinations, chiefly done in May and June, was 4519.

SUICIDE OF A PHYSICIAN.—Dr. Milligan Patchen, a recent graduate of the Bellevue Hospital College, committed suicide, in New York City, on the night of July 22d, by shooting himself through the head. He was only twenty-five years of age, and had been recently appointed one of the corps of summer inspectors of the Department of Health. No communication was left by him to show the cause of his self-destruction, and his friends state that nothing peculiar had been remarked respecting his conversation or demeanor.

CANADA.

(From our Special Correspondent.)

QUEBEC MEDICAL BOARD.—The College of Physicians and Surgeons, of the Province of Quebec, held its triennial meeting in the City of Quebec on the 11th, under the Presidency of DR. R. P. HOWARD, of Mon-

treal. In the address, reviewing the work of the past three years, Dr. Howard stated that the special prosecutor had instituted forty-nine suits against persons practising illegally. The matriculation examiners of the Board had admitted one hundred and forty-two candidates to the study of medicine and one hundred and fifty-three licenses to practice had been granted by the Board. A lengthened discussion took place on the propriety of changing the present mode of electing the governors of the College, in order to give the country districts proper representation. The matter was referred to the incoming Board. The ballot was then taken for the governors, and after the result was declared, a meeting of the new Board was held, when the following officers were elected for the next triennial period:

President.—Dr. C. E. Lemeux.

Vice-President for Quebec.—Hon. Dr. Ross.

Vice-President for Montreal.—Dr. Kingston.

Secretary for Quebec.—Dr. A. G. Belleau.

Secretary for Montreal.—Dr. F. W. Campbell.

Registrar.—Dr. L. Larue.

Treasurer.—Dr. E. P. Lachapelle.

CHOLERA.—The latest cable reports announce the appearance of cholera at Alexandria, and the death there of one European from it.

The Khedive and the Ministers have gone to Cairo to make necessary sanitary arrangements.

A Sanitary Commission, composed of General Sir Evelyn Wood, Baker Pasha, and General Stephenson, has been formed. It has decided to establish three additional hospitals at Cairo, and is organizing an ambulance corps.

The Sanitary Commission has decided that all passengers must undergo a medical examination before leaving Egypt, and it is considering permanent sanitary measures to be enforced against vessels arriving at Egyptian ports from Bombay. About Alexandria all business and agriculture has been suspended. Two months' delay in legal judgments has been granted.

At Cairo the disease has broken out among the British soldiers stationed in the Citadel, and the mortality from the disease in the city is very large. On the 21st there were 381 deaths; on the 22d, 295; on the 23d, 427, and on the 24th, 463. The disease is very sudden in its onset, and its victims frequently fall dead in the streets. It is stated that about one-third of the hospital cases die. The epidemic is spreading northward as well as southward.

At Suez the cholera has broken out among the British troops recently arrived from Cairo, and quarantine against arrivals from infected and suspected ports has been renewed. Cholera has also appeared at Ismailia.

The inhabitants of the most infected portion of Bulak have been sent to Tourah, a place ten miles up the Nile, and their houses have been burned. They are surrounded by a cordon, nothing is supplied them, and they are dying of famine. The cholera is spreading among the guards.

Cholera has also appeared at Damanhour, where crowds of people, unable to pass through the cordon, are collected, and are badly lodged and fed.

At Fareskour, eight miles southwest of Damietta, the leprosy has also appeared, and is spreading rapidly.

• At Bombay there are serious fears of the outbreak of an epidemic, as during the past week there were thirty-seven sporadic cases.

The English Government has despatched to Egypt twelve doctors who are experts in cholera, and forty have been sent from India to Egypt.

In Paris, inspectors are visiting all the houses in the

populous quarters of the city, in order to institute measures to guard against the cholera.

M. Pasteur, we learn, has offered the French Government to organize a commission to investigate the cholera in Egypt, and the Consulting Committee of Hygiene has reported in favor of the proposition. The commission will be composed, it is said, of MM. Rouy and Thuillier, assistants in M. Pasteur's laboratory; Strauss, of the Faculty of Medicine of Paris, and M. Nolacq.

With a view to the prevention of the introduction of the disease into the United States the Secretary of the Treasury, at the suggestion of Surgeon-General Hamilton, of the Marine-Hospital Service, has telegraphed instructions to the American Consul-General in London and the Consul in Liverpool, to appoint at once sanitary inspectors whose duty it shall be to inspect all vessels leaving the United Kingdom for the United States, and to inform by cable the health authorities in this country of all such vessels having disease on board or being liable to develop disease on the voyage.

This action was taken in consequence of the rumor which has reached here, that cholera had appeared in the London docks, but which, happily, has not as yet been confirmed. Full instructions to the inspectors were at once prepared by Surgeon-General Hamilton, and forwarded by the State Department on the Alaska, which sailed on Tuesday. Pending the arrival of these instructions, the inspectors will act under cable advices.

YELLOW FEVER.—There were thirty-nine deaths from yellow fever in Havana during last week.

The various commercial bodies in New Orleans, a few days ago adopted the following resolution, which was approved by the Board of Health and forwarded to Governor McEnery.

Resolved, That the Board of Health be requested to petition the Governor of the State of Louisiana to have all infected vessels now in the waters of the State removed out of the same, and that he issue his proclamation that henceforth no vessel from any infected port be permitted to enter the waters of the State.

The following resolutions were then unanimously adopted by the Board of Health:

Whereas, There is danger of yellow fever being introduced into New Orleans through unrestricted communication between Ship Island and the coast of the State of Mississippi.

Resolved, That the Governor of the State of Louisiana be requested to call the attention of the Governor of Mississippi to this fact, and urge him to take stringent measures to put a stop to this dangerous intercourse; and be it

Resolved, That the General Government be requested through the proper authority to order that no communication should be held between Ship Island and the Mississippi coast.

SUING FOR A DIPLOMA.—A member of the class of 1883 of the College of Physicians and Surgeons of Baltimore, who was rejected in his candidacy for a diploma, petitioned the Court to issue a writ of *mandamus* upon the Faculty that they shall issue his diploma to him, claiming that his rejection had damaged his character to the amount of \$2,000. After argument before the Court, the judge decided in favor of the Faculty. An appeal has been taken.

PRESIDENT OF THE ROYAL SOCIETY.—The election of Mr. HUXLEY as President of the Royal Society, in place of the late Mr. Spottiswoode, has met with warm approbation on all sides, and there is reason to hope that the Society will render still greater services to biological science than before.

BIDS FOR THE HOT SPRINGS HOSPITAL.—Bids were opened last week for erecting the proposed Army and Navy Hospital at Hot Springs, Arkansas, in accordance with plans prepared by Surgeon-General Crane, of the Army, and Surgeon-General Wales, of the Navy. The bids range from \$60,000 to \$120,000. The contract will be awarded in a few days.

DR. OSLER.—DR. WILLIAM OSLER, Professor of Physiology in McGill University, Montreal, has just been elected a Fellow of the Royal College of Physicians of London. This distinguished honor is a just appreciation of the excellent scientific work done by Dr. Osler.

ROYAL COLLEGE OF PHYSICIANS.—This College gave a *conversazione* in Pall Mall on July 4th. As usual at these meetings the attendance of visitors was large and distinguished. The guests were received by the President, Sir W. Jenner, K.C.B., Dr. Munk, and Dr. Lionel Beale. At an early period of the evening, H.R.H. the Duke of Albany arrived, and was received and escorted round the College by the President and Censors.

Among the many valuable and interesting objects of art exhibited were some Wedgwood chessmen, designed by Flaxman, lent by Dr. Braxton Hicks, and an antique Moscow enamel, lent by Dr. Alfred Meadows. The President exhibited portrait etchings of George Eliot, Stuart Mill, and Carlyle. Dr. Farquharson, M.P., lent the exquisite drawing of the Royal Academy May-Pole Dance, by Linley Sambourne.

THE LONDON MEDICAL SOCIETY.—The President, Sir Joseph Fayrer, and Council gave a *conversazione* on July 2d, at the new building of the Society, at which the Prince of Wales, Prince Lucien Bonaparte, and other distinguished guests were present.

PROFESSIONAL KNIGHTHOODS.—It is stated that the Queen intends to confer the honor of knighthood on Dr. Pitman, Registrar to the College of Physicians, in recognition of his long and faithful services to that important body, and on Mr. Edwin Saunders, F.R.C.S., for many years dentist to the royal family, and a liberal benefactor of the public institutions connected with his profession.

HEALTH IN MICHIGAN.—Reports to the State Board of Health for the week ending July 14, 1883, indicate that measles, inflammation of the bowels, cholera morbus, diphtheria, pneumonia, and diarrhoea have increased; and that intermittent fever has decreased in area of prevalence.

Including reports by regular observers and by others, diphtheria was reported present during the week ending July 14, and since, at 21 places; scarlet fever at 13 places; and measles at 23 places.

OFFICIAL LIST OF CHANGES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM JULY 16 TO JULY 23, 1883.

ELBREY, FREDERICK W., *Captain and Assistant Surgeon.*—The leave of absence granted on Surgeon's certificate of disability by S. O. 26, A. G. O., January 31, 1883, further extended six months on Surgeon's certificate of disability.—*S. O. 162, A. G. O., July 16, 1883.*

POWELL, JUNIUS L., *Captain and Assistant Surgeon.*—Assigned to duty at Fort Columbus, N. Y. H.—*S. O. 130, Department of the East, July 18, 1883.*

RICHARD, CHARLES., *First Lieutenant and Assistant Surgeon.*—Assigned to duty at Fort Adams, Newport, R. I.—*S. O. 130, Department of the East, July 18, 1883.*